MINISTRY OF HEALTH
DEPARTMENT OF HEALTH FOR SCOTLAND
MINISTRY OF EDUCATION

An Inquiry into

HEALTH VISITING

Report of a working party on the field of work, training and recruitment of health visitors

LONDON
HER MAJESTY'S STATIONERY OFFICE
PRICE 6*s* 6*d* NET

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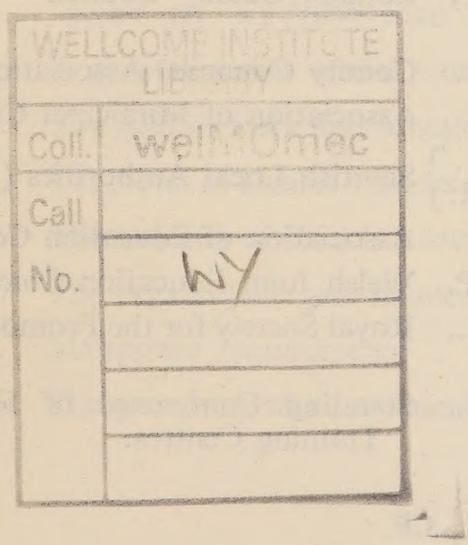

LONDON
HER MAJESTY'S STATIONERY OFFICE
1956

HEALTH VISITORS' INQUIRY

Chairman of Working Party and Steering Committee,

Sir WILSON JAMESON, G.B.E., K.C.B., M.D., F.R.C.P.

Working Party

A. Beauchamp, O.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P.
General Practitioner; Vice-Chairman Birmingham Executive Council.

Alderman Mrs. K. Chambers, C.B.E., LL.D., J.P.
Chairman of Bradford Health Committee and Bradford Executive Council.

Miss E. W. Himsworth, R.G.N., S.C.M., Q.N., H.V.Cert.
County Nursing Officer, Midlothian and Peebles.

Miss E. Stephenson, S.R.N., R.F.N., S.C.M., H.V. Cert., Public Health Administration and Nursing Education Certificate, Toronto University.
Chief Nursing Officer, Newcastle-upon-Tyne.

J. F. Warin, M.D., D.P.H.
Medical Officer of Health and Principal School Medical Officer, Oxford.

Steering Committee

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R. J. Peters, M.D., M.R.C.P.E., D.P.H. Miss L. C. Watson, O.B.E.	Department of Health for Scotland
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J. A. Scott, O.B.E., M.D., M.R.C.P., D.P.H.	London County Council
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Reverend J. A. Fisher Miss N. I. Wattie, M.B., Ch.B., D.P.H.	Scottish Local Authorities (Jointly)
E. Thomas, B.Sc., Ph.D.	Association of Education Committees
Alderman Mrs. Anne Fisher, M.B.E., J.P.	Welsh Joint Education Committee
H. C. Maurice Williams, O.B.E., M.R.C.S., L.R.C.P., D.P.H.	Royal Society for the Promotion of Health
Miss M. E. Davies, S.R.N., S.C.M., H.V.Cert.	Standing Conference of Health Visitor Training Centres.
Professor R. M. Titmuss	
Miss E. Younghusband, C.B.E., LL.D., J.P.	

Note:—The Steering Committee functioned as a purely advisory body and its members are in no way committed to the content of the Report.

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APPENDICES

INTRODUCTION

To: THE MINISTER OF HEALTH.
THE MINISTER OF EDUCATION.
THE SECRETARY OF STATE FOR SCOTLAND.

GENTLEMEN,

You appointed us in September, 1953, with the following Terms of Reference:

"To advise on the proper field of work, the recruitment and training of Health Visitors in the National Health Service and School Health Service."

We have regarded ourselves not as a representative body but as persons acting independently of any organisation to review the ascertainable facts and opinions about a body of work with which we are in varying degrees familiar through our working experience. We have, however, had the advantage of the help of a Steering Committee, appointed by you, who are representative of a wide range of opinion and experience in the services concerned and for the most part nominated by organisations directly concerned with their working. As with previous similar enquiries the professional organisations of Health Visitors were not represented in order, we understand, to leave them complete freedom of action.

Although the association of Working Parties such as ours with Steering Committees has become the usual practice in recent years, we think the relationship of the two bodies may not be generally understood. The principal function of the Steering Committee is to advise on the general form of the inquiry, on the sources of information and evidence and on the policy of any bodies that are represented. It might in fact more aptly be termed an Advisory Panel. We have received valuable help from the Steering Committee and have given full consideration to the advice offered us. We have, however, had no constitutional obligation to accept their views. We feel it necessary, therefore, to record that we accept sole responsibility for what is said in our report which does not necessarily represent the views of, or in any way commit, either the individual members of the Committee or any of the organisations that may have nominated them.

In all we have met on twenty-two occasions in London. Two of these meetings have been held jointly with the Steering Committee and on other occasions individual members have joined in our private meeting. We have also held six meetings at other centres in Great Britain.

We should like to record our sincere appreciation of the willing and valuable help given to us not only by the Steering Committee but by local authorities and other bodies and many individuals—notably in the course of our visits and local surveys. Our thanks are due also to our Secretaries who have carried out a difficult task to our complete satisfaction, and to their staff and the typing and other services provided by the Departments.

We now have the honour to present our report to you. It is long and for convenience a summary of our main conclusions and recommendations immediately follows this introductory note.

WILSON JAMESON (*Chairman*).

A. BEAUCHAMP.

K. C. CHAMBERS.

E. HIMSWORTH.

E. STEPHENSON.

J. F. WARIN.

R. PRONGER
M. H. COOK } *Joint Secretaries.*

C. E. CAULCOTT, *Assistant Secretary.*

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

BELOW are summarised the main conclusions and recommendations contained in Chapters X to XV of the Report. These do not exhaustively cover the points made in the text and are intended also to be read in the light of the general review in Chapter IX.

FIELD OF WORK AND FUNCTIONS OF HEALTH VISITORS

(i) *Functions.* The functions of Health Visitors should primarily be health education and social advice; they may usefully undertake other functions but these should arise from or be incidental to their primary functions. In carrying out all their functions, Health Visitors should have full regard to the needs of the family and the part played by other workers. (Paragraph 293.)

(ii) *Present Field of Work.* Though less frequent attention may need to be given to the physical care of mothers and young children in many cases, more attention will have to be paid to mental hygiene. While the intensity of visiting may vary, Health Visitors should keep some contact with all families where there are children. This is a major task and over-concentration on a few cases or on new work carries risks unless there are enough staff; proper attention to maternity and child welfare need not, however, preclude extension to other fields. (Paragraphs 294–296.)

(iii) In the School Health Service there is an important field for the qualified Health Visitor but her time is often wasted on duties not demanding her full skill. Duties should be re-arranged to avoid this and other staff engaged if need be. On the other hand, the Health Visitor might be an invaluable addition to the child guidance service. She could do more for handicapped children and might play a larger part in health education in schools. We strongly support the policy of amalgamating the Health Visiting services of the local health and education authorities. (Paragraphs 297–301.)

(iv) *New Possibilities of Service.* Health Visitors have been primarily concerned with the prevention of ill-health among the healthy, but they have also, for example, played a large part in tuberculosis work and this should in future be regarded as a field of work calling for the services of qualified Health Visitors. (Paragraphs 302–303.)

(v) Tuberculosis work shows how Health Visitors can play a prominent part in the development of hospital after-care as a whole. Where after-care measures are necessary for the recovery and the welfare of the patient and his family, the Health Visitor has a part to play. She will necessarily work with the family doctor in such matters. (Paragraph 304.)

(vi) The general practitioner is now much more concerned with the health of whole families and especially with mothers and children, with the problems of old age, handicap and chronic illness and with the preventive and

social aspects generally of illness. He is tending to become the clinical leader of the domiciliary health services team. The Health Visitor is admirably placed to help him. She could be useful to him in any part of his practice where health education and social advice are desirable. (Paragraphs 305–307.)

(vii) Health Visitors can play an important, if unspectacular, role in relation to mental health. While their main importance may be in helping mothers, they should be able to take account of psychological factors in any case with which they deal. In established mental illness experts are needed, but the Health Visitor can help in suitable cases. (Paragraphs 308–310.)

(viii) The Health Visitor can do much to help the aged whether or not in need of medical care. She can assist in the ascertainment of their social needs and should be brought into schemes for official or unofficial help. She may play a similar part in the care of handicapped adults (but will be less closely concerned than in the case of children). (Paragraphs 311–312.)

(ix) She should undertake the supervision of mentally defective children as part of her normal home-visiting duties, seeking specialist help where needed. The care of older defectives will usually call for the services of a specialist. (Paragraph 313.)

(x) *A Family Visitor.* In association with the general practitioner, the Health Visitor will be concerned with a wider range of families than any other comparable worker. She will be in touch with the various family health and welfare teams. She has thus the opportunity to act as a common point of reference and source of standard information, a common adviser on health teaching—a "common factor" in family welfare. In the ordinary course of her work and without exceeding her competence, she could be in a real sense a general purpose family visitor. (Paragraphs 314–316.)

The Status of Health Visitors and their Relationships with Others

(xi) *Status of the Health Visiting Service.* The work of the Health Visitor is distinct from that of both nurses for the sick and social workers. While she will base her work on the advice of medical and social experts, she will exercise her own judgment in applying it to her work with families. She will be truly a medico-social worker—playing a full part in both preventive medicine and social action. The Health Visitor's work will extend to a wider variety of cases and she will be more concerned with non-medical aspects. Administrative arrangements should take account of this. She should be answerable to her own professional head and the latter in turn to the medical officer of health. (Paragraphs 317–318.)

(xii) While retaining individual responsibility for their own families Health Visitors should, where possible, work in small teams covering one area for all purposes. They should have a proper base—possibly at a clinic—with facilities for private consultation, clerical help and a telephone, and should be free to organise their day to day work and co-operate with other workers without detailed central control. Their location should be widely known. (Paragraphs 319–321 and 323.)

(xiii) At maternity and child welfare clinics, Health Visitors should be able to concentrate on health education and they should be relieved of duties that distract them from this. (Paragraph 322.)

(xiv) *Co-operation with Home Nurses and Midwives.* The association of Health Visitors and home nurses with general practice will make their close co-operation essential; the future training of both should do more to prepare them for this. While the midwife will have the major concern with the ante-natal and neo-natal periods, the Health Visitor has an important educational role. Where the midwife is called on to assess the need for admission to maternity hospitals, the Health Visitor should be consulted. She should usually take responsibility for care on the mother's discharge from hospital or, in home confinements, from the fourteenth day. There should be a case discussion and joint visit at this juncture. (Paragraphs 324–326.)

(xv) *Combined Work.* The weight of opinion is in favour of full-time Health Visitors. It seems likely that Health Visiting as we visualise it for the future will call for a full-time highly trained worker. We do not recommend therefore that combined work should be a general principle of organisation but see no sufficient grounds for altering the arrangements in areas where combined work is the established practice, provided all such workers are qualified Health Visitors. (Paragraphs 327–329.)

(xvi) *General Practice.* The relationship of the Health Visitor with the general practitioner will be more like that between consultant and almoner in hospital than the relationship of doctor to nurse. Co-operation will be easiest where Health Visitors are organised in area teams; liaison arrangements can meet the needs of scattered practices. The first step to co-operation is the development of a common local policy between the local health authority and general practitioners; the second, to arrange for Health Visitors and general practitioners to meet; the third, to channel all the doctors' less urgent, complex or technical demands for local authority services through the Health Visitor. (Paragraphs 330–332.)

(xvii) *Hospitals.* Health Visitors must have a close working arrangement and personal contact with almoners and ward-sisters. Hospitals must provide relevant information and know where Health Visitors can be found. The special case of tuberculosis illustrates the relationship with hospital out-patient departments. The Health Visitor's work should be strictly related to her functions and extraneous duties should be performed by others. (Paragraphs 333–334.)

(xviii) *Social Workers.* Wherever there is a need for home visiting for family welfare purposes, consideration should be given to the help that can be given by the Health Visitor, already in touch with the family for other purposes, to avoid duplication of visiting and the creation of new types of staff. In some sorts of cases the social case-worker has special advantages. A vital aspect of Health Visiting will be recognition of such cases, ability to find the right kind of help and ability to co-operate in any measures taken. (Paragraphs 335–336.)

(xix) *Specialisation in Health Visiting.* We deprecate specialisation because it narrows the field of interest, complicates family visiting, reduces the opportunity for service by the general duties staff and thus lessens the

attractiveness of the profession. Much of what is now specialised could be incorporated in general duties. If specialisation is unavoidable (because there is an exceptionally serious problem or special aptitude or training is needed), staff should, if possible, retain a small area for general duties purposes or return from time to time to general duties work. (Paragraph 337.)

(xx) *Group Advisers.* Some experienced Health Visitors have exceptional ability and, with further training, could occupy "group adviser" posts intermediate between general duties and administrative staff with increased responsibilities. They could provide close support for general duties staff over the whole range of duties, act as the medium of referral in difficult cases and themselves take over cases needing intensive work. They would organise liaison with other professional groups, co-ordinate health education, arrange for students to get practical experience and take new recruits under tutelage until well established. They would help with the further education of staff. The grade should be in course of time a step towards administrative and teaching posts. (Paragraphs 338–339.)

The Training of Health Visitors

(xxi) *Maternity Training.* Part I of the midwifery examination is not a satisfactory preparation for Health Visitors' work of health education in the ante-natal and neo-natal period. Special courses of not more than three months' duration would enable students to gain sufficient knowledge and experience of maternity care for their purposes as domiciliary workers. The courses should be organised by the Health Visitor training bodies, in conjunction with those responsible for midwifery training. When courses are established, Part I of the midwifery qualification should accordingly cease to qualify students for entry to Health Visiting training. (Fully trained midwives would of course be admitted without further training.) (Paragraphs 341–345.)

(xxii) *Nurse Training.* Objections to nurse training as an element in Health Visitor training are outweighed by the practical advantages, especially in view of changes in the aims of nurse-training and of the widening of student nurses' hospital experience. The training must, however, be of the character of general nursing. In the light of experience it would be unwise to recommend that registration as a nurse should cease to be one of the qualifications of Health Visitors. (Paragraphs 346–350.)

(xxiii) *Public Health Training.* Courses should aim not at producing the complete Health Visitor but at providing a clear picture of family health and welfare services and giving the essential additional technical knowledge. Only students should be selected who have the qualities to take such a course and become successful practitioners; moreover, new recruits should not be expected by employers to assume full responsibility at once without guidance and support. (Paragraphs 351–353.)

(xxiv) Courses should be practical in their approach to all aspects of the work. They will build on the foundation of nurse and maternity training, adding new knowledge and relating previous knowledge to the facts of domiciliary practice, especially in association with general practitioners and

hospitals. Practical knowledge of home management is necessary. A knowledge of the social service agencies likely to be available in an area and how to work with them is essential. Much emphasis should be laid on the family welfare aspects of all visiting and on " mental hygiene ". Teaching methods should aim at maximum student participation and practical experience should be given wherever possible. (Paragraphs 354–359.)

(xxv) The length of the public health course should be at least nine and need not exceed twelve months. The overall length of training would be four years or four years and three months. (Paragraph 360.)

(xxvi) *Integrated Courses.* The best method of training Health Visitors would be by integrated courses, embodying maternity, nurse and public health training and keeping the eventual career in view from the outset. One such course is already at an advanced stage. We endorse such experiments and hope that eventually integrated courses will be the mode of training of the majority of recruits.

Integrated courses are intended for direct entrants to Health Visiting. These may not be attracted in the numbers hoped for unless the total period of training can be shortened. We hope that the possibility of shortening the nurse training element in integrated courses—without reducing their effectiveness—can be discussed by the training bodies concerned. Integrated courses offer special opportunities for such experiments.

The recommendations of the Nurses' Working Party (1947) suggest possibilities of experimentation which would hold marked advantages for Health Visitor training. Integrated courses might be an ideal field for experiments under the Nurses' Act, 1949.

There may well be room for a number of experiments in training for Health Visiting. (Paragraphs 361–364.)

(xxvii) *Further Training.* Health Visitors should be given facilities to improve their professional knowledge, including attendance at conferences, national and local, that bear on their work. All Health Visitors—qualified or unqualified—should be enabled to attend refresher courses approved by the central training bodies once every five years. (Paragraphs 365–366.)

(xxviii) *Advanced Training.* Universities should be invited to set up diploma courses for suitable Health Visitors with at least five years experience to enable them to qualify as " group advisers ". (Paragraph 367.)

(xxix) Adequate tutorial staffs must be trained and one or two special university courses will be needed to make good immediate shortages. Thereafter, regular courses would be unnecessary. The diploma courses for group advisers should also be an adequate preparation for the junior grade of tutor. (Paragraph 368.)

Organisation and Finance of Health Visitor Training

(xxx) Training courses for general duties staff would not have the character of courses for a university diploma or degree, but it is most desirable that universities should be associated with training arrangements at all levels. All courses should be within the sphere of influence of a university. (Paragraphs 369–370.)

(xxxi) *Central Training Bodies.* Apart from the control of the syllabus and examinations, the central training bodies would decide where centres should be established, approve the constitution of the managing body, the administrative arrangements and the curriculum of Health Visitor training. They would encourage experimentation especially in integrated training. They would approve maternity and refresher courses. They would issue certificates of qualification or authorise certain training centres to do so. There need be no formal register but practice should be restricted to qualified staff by statutory instrument. (Paragraphs 371–373.)

(xxxii) The constitution of the central training bodies should provide for representation of all the principal interests. Health Visitor, training centre and university interests should together have a slight majority. Both an executive and an advisory body might be needed. Consultation with unrepresented interests would be necessary. (Paragraph 374.)

(xxxiii) The Royal Society for the Promotion of Health and Royal Sanitary Association for Scotland might be invited to reconstitute their appropriate committees to enable these to assume the functions of the central training bodies. If they are unable to do so, separate bodies should be established. (Paragraph 375.)

(xxxiv) *Training Centres.* Each centre should be managed by a training centre committee, responsible for arrangements for maternity courses and Health Visitor courses, of which some centres might provide more than one. The committees should have final responsibility for selecting students. Their constitution should reflect local circumstances but generally should be similar to that of the central body. Teaching staff should be represented. Special consideration would need to be given to the position of universities undertaking responsibility for courses. (Paragraphs 376–377.)

(xxxv) *Financial Arrangements.* All training expenditure should be met from a central fund financed by contributions from local health authorities on an agreed basis and administered by the central training bodies under government supervision. (Paragraphs 378–379.)

(xxxvi) Financial assistance to students should be in the form of standard allowances paid by training centres from the fund to approved students, that is, students accepted for employment by a particular authority or others who undertake to serve in an understaffed area. Allowances would be subject to an undertaking to serve the authority for a period of two years. (Paragraph 380–382.)

Manpower

(xxxvii) The traditional bases for assessing the work-load of Health Visitors are not wholly satisfactory as a measure of the extended scope of the work. We have suggested principles on which the work-load could be uniformly assessed by each authority. According to our estimates on such a basis, the standard load of visiting for a Health Visitor would be about 2,000 visits a year. A total of some 20 million visits might be needed in England and Wales. Applying these estimates to Scotland also, a total force of 11,500 whole-time Health Visitors might be necessary. This should be the approximate target—representing an increase of 3,500 whole-time Health Visitors. (Paragraphs 384–397.)

Prospects of Recruitment

(xxxviii) The period of development is assumed to be ten years. In this period some additional 3,500 Health Visitors would need to be recruited. To reach and maintain this figure the number of staff trained annually must be increased from 640 to 1,100. (Paragraphs 398–399.)

(xxxix) *The Recruitment Pool.* Recruitment now depends on the number of general nurses who enter the Register annually and the number available for training as Health Visitors who are in all respects suitable. This may not exceed 2,250 nurses annually. It is unlikely that all the Health Visitors needed can be obtained through post-registration courses. It is, therefore, not only desirable but necessary to establish integrated courses embodying nursing and Health Visitor training with an appeal to direct entrants to the work. (Paragraphs 400–401.)

(xl) *The Stimulation of Recruitment.* Information about Health Visiting and training facilities must be brought to the notice of trained nurses and school-leavers particularly. A central advisory service would be valuable. (Paragraphs 402–406.)

(xli) Great importance attaches to the enhancement of the professional status of Health Visitors and to our recommendations for the improvement of working conditions and the removal of unnecessary duties. (Paragraph 407.)

(xlii) Health Visiting must be made financially attractive to able trained nurses. There should be a financial incentive to take the training. Salaries should be reviewed accordingly. (Paragraphs 408–409.)

(xliii) A review of senior staff scales of salary will eventually be needed, to take account of the unification of services that we recommend. A new scale for group advisers will be needed. This should be the same as that of the junior tutorial grade. Health Visitors selected to help with practical training should receive allowances. (Paragraphs 410–413.)

Part I. Preface and Evidence of Opinion

PREFACE

1. It is desirable to sketch briefly the history of Health Visiting up to the time when our work started(1).

2. The title to consideration as the first organised Health Visiting movement seems to be accorded to the Ladies' Sanitary Reform Association of Manchester and Salford who organised such work in 1862. They employed paid visiting staff who were enjoined to visit all and sundry in their district, concentrating on cleanliness, good management and good living, helping the sick and advising mothers on the care of their children.

3. Though Manchester and Salford Councils soon took some responsibility for the work, the first whole-time staff in local authority employment seem to have been engaged by Buckinghamshire in 1892. These were the product of a training scheme of which Miss Florence Nightingale was the inspiration. Her views on the subject are interesting—" It seems hardly necessary to contrast sick nursing with this [Health Visiting]. The needs of home health-bringing require different but not lower qualifications and are more varied. . . . She [the Health Visitor] must create a new work and a new profession. . . ."

4. Other authorities followed suit in employing visiting staff. Physical and environmental health in a pretty broad sense seem to have been the field of the Health Visitor, but the care of mothers and young children was an obvious problem. Notification of births under the Acts of 1907 and 1915 provided the means of identifying the problem, and the Maternity and Child Welfare Act of 1918 perhaps completed the task of concentrating the attention of Health Visitors on this work.

5. A similar line of development was apparent in Scotland. Late in the nineteenth century, five " female sanitary inspectors " had been appointed in Glasgow. In 1902, a " sanitary inspectress " was appointed in Aberdeen to visit homes with a view to improving their hygienic condition. In 1903, Dundee appointed two " Health Visitors ", mainly to teach mothers the rules of health and advantages of cleanliness. In Leith, in 1902, all the homes where a death occurred from infantile diarrhoea were visited by a " lady sanitary inspector ".

6. The staff employed in the early years were various. The work could have fallen it seems to doctor, nurse or social worker alike. Many of the earlier Health Visitors were women sanitary inspectors. The London County Council under a special Act passed in 1908 prescribed qualifications which included, for example, either a medical degree, three years' nursing, or midwifery besides some training in nursing and the Health Visitors' certificate of a society approved by the Local Government Board.

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(1) For the earlier history of Health Visiting in England and Wales we have referred to McCleary, G. F. (1935) " The Maternity and Child Welfare Movement ". King.

7. Specific professional training courses were organised by various bodies but no generally recognised form of training existed for Health Visitors until 1919, when the Ministry of Health and Board of Education jointly promulgated a scheme for a two year course of training, normally to be associated with a University institution, which should include training in social science and domestic subjects. Trained nurses, graduates and women with three years experience of Health Visiting might take a one year course. At this time, no midwifery qualification was required.

8. In 1919 also, the Scottish Board of Health issued "Conditions for the Certification and Registration of Health Visitors", similarly providing for two types of training, one for trained nurses and one for persons without any previous nursing experience.

9. That year saw also the passage of the Nurses' Act, which provided for the first time for statutory regulation of nurse training. The newly constituted General Nursing Councils established uniform rules for nurse training normally of three years' duration. It may well have been the creation of a new recognised nurse training that led to the revision of Health Visitor training in 1925. In that year, the Minister of Health issued Memorandum 101/M.C.W. which was the basis of future arrangements. Already in 1922, courses of less than one year had been permitted for trained nurses. Henceforward, the minimum length of the course in public health work was made six months for trained nurses. All Health Visitors were required to be trained midwives (the training lasting only six months at that time). The alternative form of entry was retained and is still recognised, in England and Wales, even now. This would require students, who had had, or undertook to gain, at least six months nursing experience in hospital, to undergo a Health Visiting course of two years' duration. In the event, the trained nurse entrant seems to have proved more acceptable to medical officers. Though one or two students continued to take courses of the alternative type until 1944, no substantial number has qualified in this way for many years. In Scotland, when new grant regulations were made in 1932, no provision for candidates without nurse training was made.

10. Under revised rules of the two Central Midwives Boards, midwifery training was divided into two parts, in 1938 in England and Wales and in 1939 in Scotland. For trained nurses, the two parts were each of six months duration—the first in hospital and the second in domiciliary work. Health Visitors were required to take only the hospital part. Thus, if they took the minimum required training, its overall length was unchanged; but, unless they completed the course voluntarily, they lacked domiciliary midwifery experience.

11. By the mid-thirties, schemes for the care of mothers and young children were well established. The Health Visiting force was nearly as strong as at the present day and its position in maternity and child welfare and in the schools clearly recognised. The war and post-war social welfare legislation brought great changes.

12. The National Health Services Acts, 1946 and 1947, greatly affected Health Visiting. In England and Wales the service became the statutory responsibility of the Counties and the County Boroughs to the exclusion of the District Councils and voluntary effort tended to disappear. (In Scotland, the Counties had been concerned with Health Visiting to the exclusion of the

small burghs since 1930.) While, since 1930, local authorities had been required to appoint fully qualified Health Visitors to their full-time posts, the requirement had not been laid on voluntary associations. With the transfer of work, County and County Borough Councils inherited considerable numbers of staff unqualified save by experience. In 1948, Regulations(1) were made by the Minister of Health requiring the appointment of qualified Health Visitors to all posts whether full or part-time, official or voluntary, unless with the Minister's consent. A little earlier, Regulations(2) had been made under the Education Act, 1944, requiring all nurses appointed since 1945 to be qualified Health Visitors, where possible (except in specified cases). Both these measures tended to intensify the demand and the consequent competition for always scarce qualified staff.

13. In Scotland, it was not found practicable to issue Regulations comparable with those made by the Minister of Health. Authorities were, however, encouraged to employ qualified staff and to arrange where possible for nurses employed in Health Visiting to acquire the Health Visitors' certificate.

14. While the School Health Service—and certainly the work of the Health Visitor within it—remained relatively unchanged by post-war legislation, the social welfare legislation of 1946–48 had considerable effects on the other branches of Health Visiting. On the one hand, the Children Act, 1948, removed responsibility for certain aspects of child care from the Health Department. On the other hand the amalgamation of the mental health services in the main body of the National Health Service, the creation of general care and after-care powers and above all the extension of the functions of the Health Visitor in Section 24 of the English and Scottish Acts, opened up for Health Visitors much wider opportunities for service. These Sections required the Health Visitor, as well as carrying out her existing functions, to give " advice as to the care of persons suffering from illness and as to measures necessary to prevent the spread of infection ". Departmental circulars emphasised the intentions of the Sections, mentioning that " illness " included mental illness and any injury or disability requiring medical or dental treatment or nursing. The circulars continued: " this involves an extension of the functions now normally assigned to a Health Visitor . . . after the Appointed Day she will be concerned with the health of the household as a whole, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education. She will work in the closest co-operation with the family doctor and will not encroach on the province of the nurse . . . or of the sanitary inspector ".

15. It will be seen that a wide field of interest was given to Health Visitors but that their functions within the field were not precisely defined. There was a broad hint that they were intended to be largely educative. It would have been difficult to be any more precise for changing social circumstances in war and post-war conditions have given new prominence to some forms of need and disclosed others and the patterns of need are still changing. Until a clear picture emerges—perhaps not for some years yet—

(1) National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948—S.I. No. 1415.

(2) Handicapped Pupils Regulations and School Health Service, 1945 (S.R. and O. 1945, No. 1076) superseded by the School Health Service and Handicapped Pupils Regulations, 1953 (S.I. 1953, No. 1156).

it will still be unwise to attempt to prescribe too rigidly the form of organisation required to meet family welfare needs or the functions of family health and welfare workers. The trend, however, very clearly has been for the well-being of the family as a whole to become the main objective of health and welfare activities of many kinds. Just as Health Visitors have been and are still concerned mainly with one aspect of family life—the health of mothers and children—other types of workers with particular interests have developed to meet other special needs. These workers usually have had a non-medical background of training and experience. The overlapping of activities has become apparent because the training and function of all these workers are still often unco-ordinated. The extent of the confusion is illustrated by a number of reports which demonstrate that clarification is necessary. Among these is a survey of family health and welfare workers in England (kindly made available to us by Professor A. L. Banks, who has undertaken it as part of a larger inquiry)(1). Yet those surveys have also demonstrated that, desirable as a comprehensive approach might be, it could easily flounder in a mass of complexities that a series of studies of narrower scope might avoid. It was perhaps natural that the Government should consider that the first study in such a series should be a review of the role of the most numerous existing body of home visitors whose predominant interest has been health. The first step was taken at the invitation of the Government by the Nuffield Provincial Hospitals Trust which contributed a survey of the work of Health Visitors as part of an analysis of the work of public health nurses generally, in 1950. Their report was circulated privately early in 1953 and our work commences at the point where they left off. Recently a second study has been initiated which is concerned with the work of those whose work in the health and welfare services is primarily concerned with the social field(2).

16. Our terms of reference are wide in the sense that the field of the National Health Service and School Health Service is itself wide. The Health Visitor is in the difficult position—indeed dilemma—of being in every sphere of her activity only one, if in many respects a major, contributor to the total effort so that some thought must be given to the work of other contributors also. There are, also, restrictions on our terms because they are limited to the administrative responsibilities of the local health and education authorities (with however a natural extension to the work of hospitals and general practitioners) and, therefore, we have not been able to take full account of the work of other bodies who may be concerned with the health and welfare of the family. We were restricted in our activities moreover in the sense that, if our report was to form a useful part of a more general survey and not to be out-moded by events, our time was not unlimited. Though we have not been engaged full-time on the work we have met as frequently as we could to expedite it; even so we are conscious that our task has taken longer than we had hoped.

17. We considered how to tackle our inquiry with all these factors in mind. It was clear that in a field which would prove highly controversial,

(1) "Survey of Family Health and Welfare Workers: Report on the Investigation in England"—Banks, A. L., Department of Human Ecology, Cambridge. (This survey, as yet unpublished, is to form half of a study of work in England and France, sponsored by World Health Organisation and Rockefeller Foundation.)

(2) Working Party on the Recruitment and Training of Social Workers in the Health and Welfare Services (Younghusband Committee).

and in which co-operative effort must be an important factor, we needed to sound a wide range of opinion. The views put before us in this way are set out mainly in Chapter I. We had before us in addition to relevant official statistics the report of the inquiry conducted by the Nuffield Provincial Hospitals Trust, discussed in Chapter III. We considered carefully how far we could supplement the Trust's Report by a study of the content and value of the Health Visitors' actual work in the home—their work in clinics being, we thought, sufficiently well understood. On this we took much advice but eventually concluded that we should not be justified in undertaking such a comprehensive inquiry for a number of reasons. The investigation of the content of the Health Visitor's work in the home would imply an assessment of the relationship between her and her clients; some of us thought such an assessment wholly impracticable on the ground that relationships of this kind may well be altered merely by the process of observing and measuring them; and most of us did not care for methods of assessment suggested to us. Moreover, any attempt to evaluate the work of Health Visitors must involve an evaluation of the work of others who contribute to the same purpose, bearing in mind that not only the existing functions of Health Visitors but others that might be proposed for them would have to be considered. We did not consider ourselves the appropriate body to make such a comprehensive evaluation, which would have required investigations beyond our field of reference.

18. Clearly it was necessary to determine the number of Health Visitors and consider the general nature of their work in statistical terms and we embarked on surveys which are described in Chapters II and VII. To add to the information obtained from formal evidence and statistics, however, we carried out a number of visits to discuss at first hand with Health Visitors, those who employed them and those who worked with them, the practical problems facing the Health Visiting service in the field. We visited eight areas where we received unstinted help to make whatever enquiries seemed appropriate to us. Associated with the discussions in six of these areas were surveys of the work of a sample of Health Visitors conducted by independent observers. The surveys had the objects of helping us to assess the problems in the area and of supplementing and clarifying our central investigations. We did not of course expect that they would be statistically significant in the sense that they would enable us to draw firm conclusions about the character of Health Visiting in the country as a whole. As it turned out, however, they provided some useful corroboration on a number of points. These parts of our inquiry are described in Chapters II, V and VI. We also made certain inquiries about the numbers of students attending and likely in future to attend training centres and collected information about training arrangements. These subjects are dealt with in Chapters VII and VIII. The remainder of our Report—Chapters IX to XVI—consists of a review of the situation and our recommendations.

19. For some time before we started our work a Committee appointed by the Scottish Health Services Council had been considering the training of Health Visitors and its report was made available to us. Its Chairman, Dr. Wattie, joined our Steering Committee in a representative capacity. One of its members, Miss Himsworth, joined us as a member of our Working Party. During our visit to Glasgow we had the advantage of a most valuable

discussion on the mental hygiene role of the Health Visitor with Professor Ferguson Rodger, a member of the Committee. We have paid full regard to the views expressed by that Committee in reaching our own conclusions.

CHAPTER I

EVIDENCE FROM EMPLOYERS', PROFESSIONAL AND EDUCATIONAL ORGANISATIONS

20. The range of controversial questions surrounding the Health Visiting service is wide and the questionnaire we sent to the many organisations with a direct interest was formidable. All were good enough to reply, most dealing with all the questions raised, some at great length. We were glad to have, too, valuable memoranda from other bodies whom, for a number of reasons, we did not feel justified in approaching at the outset. We met representatives of most of the bodies who presented memoranda. Some witnesses supplied much supplementary material following their oral evidence. A list of witnesses who gave written or oral evidence is given in Appendix I.

Range of Duties

21. The first three questions we asked dealt with the range of duties on which qualified Health Visitors should be employed and what might be involved in them. As a basis of discussion we suggested the following general headings:

Maternity and child welfare.

School nursing.

Group health education.

Tuberculosis services.

Venereal diseases.

Infectious diseases.

Mental illness.

Mental deficiency.

Care and after-care of acute and chronic illness.

Health and welfare of the aged or handicapped.

Duties associated with the work of the Children's Department.

Co-operation with general practitioners.

Co-operation with hospitals.

Co-ordination of family welfare services.

22. Almost all witnesses took the view that the above list represented the fields of work in which the Health Visitor could be employed but a number of reservations were made about some of them. Some medical opinion and

some employing authorities favoured the limitation of work for the aged and handicapped to ascertainment and supervision of specific health problems. Many doubted whether, without special training, the Health Visitor could play a useful part in the care and after care of the mentally ill. A distinction—by no means always clear—was drawn generally between this work and "mental health" work, for which most witnesses agreed the Health Visitor was eminently well-placed. In the case of mental deficiency, a few witnesses doubted whether she should do more than help in the early discovery of mental defectives in need of care, either because the work was too specialised or because it was time-consuming.

23. Witnesses, especially the Scottish employing authorities, had a number of suggestions for extending the work of Health Visitors. Some of these seem to have been intended as further extensions of the range of duties. Among these were participation in research and special inquiries; training of medical students, Health Visitor students, student hospital and home nurses and nursery nurses; supervision of home help schemes. Other suggestions dealt rather with special aspects of the duties set out in the questionnaire, for example, prevention of home accidents (much stressed); advice on household management; health and welfare of adolescents and the older age-groups; social assessments for admission to hospital (especially maternity); immunisation of children; and assessment of housing need on health grounds.

24. General comment on the range of work was made by some organisations. One body representing English local health authorities, for example, pointed out that inconsistency in the interpretation of Section 24 of the National Health Service Act, 1946, had produced almost infinite variation in Health Visiting practice in different types of area. While expressing themselves as generally satisfied with the present Health Visitor and the quality of her work, this body suggested that a major decision on principle was needed to determine whether primarily she should concentrate on the "health" or on the "social" aspects of the work. This would affect her relations with workers within and outside the scope of the health and education departments. The Royal Society for the Promotion of Health[1] noted that it was necessary to train Health Visitors on the assumption that all would cover the widest range of work (though in fact relatively few might do so at present). On the other hand, other witnesses doubted whether any worker, however highly trained, could hope to achieve uniform success in the range of duties set out, still less add to them. All witnesses agreed that the Health Visitor's most important work was among mothers and young children, the emphasis being placed sometimes on physical, sometimes on psychological aspects. Such work was important for its own sake and it also provided the Health Visitor with an opportunity of gaining the confidence of the family through her relationship with the mother.

25. Broadly, there was agreement on the part of all witnesses that the main *function* of the Health Visitor in connection with any of the duties should be educative and advisory. Almost all witnesses agreed, for example, that the Health Visitor, as such, should not undertake nursing and midwifery duties, though some Scottish opinion was more inclined to favour this arrangement. There was general approval of demonstrations by Health Visitors of nursing and comparable techniques.

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[1] Until August, 1955, known as the Royal Sanitary Institute.

The main difference of view was over the precise field in which the function should be exercised and over the limitations on its value. The Institute of Almoners, whilst accepting that Health Visitors could work effectively over the whole field described (and welcoming co-operation with them), were at pains to show that "educative and advisory" functions did not imply the employment of Health Visitors on problems where specialised training in case-work techniques was necessary; neither the Health Visitors' training nor their case-loads were adapted to this.

The Society of Medical Officers of Health on the other hand appeared to claim that the Health Visitor, trained and employed as a "medico-social worker", could carry out duties well beyond the boundaries of the local health and education service, greatly reduce, in time, the need for certain highly trained workers and perhaps supersede others. They were supported by other witnesses with similar interests, though not all would go so far.

26. Many of the witnesses described in some detail the nature of the work to be done by Health Visitors in the various branches. The effect of their suggestions is described in the following paragraphs.

27. In maternity and child welfare work, the Health Visitor was generally expected to play a part in the ante- and post-natal periods, though there was disagreement about her relationship with the midwife. A few wanted the Health Visitor to play a more prominent part in the general care of the mother. The Royal College of Midwives and Central Midwives Board, however, thought she need not appear on the scene, except for specific health education purposes or to deal with social problems, until at least twenty-eight days after the birth. There were divergent views on the question whether the Health Visitor or the midwife should assess the social necessity for admission to hospital. Some held that the Health Visitor could better assess social conditions than the midwife: others stressed that the important point was whether the midwife was confident of her ability to manage a confinement in the conditions existing. Many recommended a closer link between domiciliary and hospital maternity services. Opinion was, however, divided as to whether this could be brought about by associating domiciliary and hospital midwives or whether the Health Visitor herself should enter the hospital ward or department for health education purposes.

28. The importance of visits to mothers with children in their homes as distinct from clinic contacts was underlined. It was accepted that "problem families" needed special attention and one or two witnesses wanted Health Visitors to concentrate on any children living away from their own homes or on sick children or children with defects. At the same time, there was obvious uneasiness lest concentration on the "hard case" should reduce the level of service available to mothers in general. The point was made repeatedly that the Health Visitor should be the "friend and adviser" of all families in all their problems. We may note especially the view of the Association of Psychiatric Social Workers that since the Health Visitor had access to the mother during the vitally important early years of the child's upbringing, when also the mother might be most receptive, she might play an increasingly important part in the "encouragement of healthy adjustments and relationships between parent and child, to minimise the anxiety of the inexperienced young mother and to build up her self-confidence". Scottish members of the Society of Medical Officers of Health said that

" intimate knowledge of families " was necessary. A middle position, perhaps, was that of the English members of the Society, who thought that it should be possible to visit all parents if necessary but that clinic work should be so adjusted that more visiting could be done in the homes where the need was greatest.

29. The position of the Health Visitor at child welfare clinics was not defined by most. The County Councils Association thought she should be in " control of staff " and therefore of administrative arrangements generally in the clinic, and probably this represents the majority view. Vis-a-vis medical officers attending clinics, her duty would be to refer cases to him and make sure his advice was understood and followed.

30. In the remainder of the fields mentioned at the head of this Chapter—except tuberculosis and school health with which we deal separately—clients may fall to a greater degree within the responsibilities of other workers or administrative departments with a major interest in the client's needs. One important body of opinion allocated no specific function to Health Visitors in these fields but expected that mutual help would be given by and to Health Visitors in households, when the problems arose. Most others simply expressed concern that the time of Health Visitors should not be dissipated on routine visiting for purposes not concerned with health education and few specific suggestions were made as to the nature of the work. In the care of the aged, however, some Scottish employing authorities suggested that the Health Visitor should give advice on diet, foot care and general hygiene. They thought she should display friendly interest and visit when required but that she should call in the specialist whenever needed. Others pressed the claims of the elderly and, especially, mothers in later middle-age for help in what was described as " preparation for retirement ", i.e. physical and mental adjustment to the processes of approaching old age—a delicate task. The Women Public Health Officers' Association would have the Health Visitor make the first assessment of needs of the aged and continue supportive visiting ; the Royal College of Nursing recommended that whatever help the Health Visitor could give should be offered to welfare departments, including help with the handicapped (about whom as a class little is said specifically in the evidence).

31. Little definite was said about work with infectious diseases or venereal disease. With regard to the former, the general view seemed to be that the Health Visitor's work should consist of health education, advice on the prevention of infection, follow-up of discharged cases and assistance in inquiries both at school and in homes, where necessary in co-operation with the sanitary inspector. Contact tracing and the follow-up of defaulters were the chief functions mentioned in venereal disease work, though the work was said mainly to be confined to women.

32. As has been noted, many witnesses thought that Health Visitors could give only limited help to the mentally ill and defective. Most witnesses expected her to co-operate with the psychiatric social worker who was, however, rarely available and presumably in her absence, therefore, with the mental welfare officer—in Scotland, a welfare department officer. The English Society of Mental Welfare Officers—and their Scottish counterpart—considered that the special features of mental illness and mental deficiency, the

exceptionally wide range of social problems raised and of helpful contacts needed, called for a specially trained worker, who need not have the general nursing background that the Health Visitor required. The work was too time consuming for a worker with a wide range and great number of clients. As many men as women were needed and the inseparable legal duties associated with removal were better carried out by men. The Women Public Health Officers' Association thought Health Visitors might be useful in the recognition of mental illness, in encouraging patients to seek and follow medical advice, in keeping the family doctor informed and securing such help as seemed appropriate. The Association of Psychiatric Social Workers agreed that early recognition could be of great value. Like the Mental Welfare Officers they were inclined to think that the observation and referral of incipient illness were part of the mental hygiene work which—as they saw it—was the Health Visitor's more important work. While distinguishing this from the cure and care of recognised disorder, they thought that the Health Visitor might well learn how best to support families in which mental illness occurred, especially in mild cases where admission to hospital could not at once be arranged or home care was possible.

Specialisation by Health Visitors

33. This term may be applied either to duties limited to one main branch, such as tuberculosis, or to some particular part of one branch, such as the care of premature babies, which we refer to as "fractional specialisation" in this Report. It was clear that most of our witnesses had both possibilities in mind though the examples quoted usually covered only the first.

34. No witness was strongly in favour of specialisation. Some of the reasons given against it were that no single specialty could give full professional satisfaction, the likelihood of multiple visiting of homes was increased, resources were wasted, and the stigma of certain misfortunes came to be associated with the specialist visitor. Scottish witnesses showed greater favour to specialisation in large urban areas where not only tuberculosis and venereal diseases, but school health services, maternity and child welfare, care of the aged or handicapped or the mentally ill or mental defectives might all be necessarily specialist branches. Two witnesses thought health education itself should be specialised work, the specialist acting as a consultant and stimulant to her colleagues and as the organiser of health education and lecturer-general on health matters. A few witnesses expressly recommended fractional specialisation—the care of premature babies or after-care of certain illnesses—but to a limited degree only.

35. The two specialties most commonly, if reluctantly, accepted as possibly necessary were tuberculosis and venereal diseases, usually with the proviso that specialisation should continue only for as long as necessary in areas with a high incidence of cases or other exceptional circumstances. In the case of tuberculosis, the main reason given was the necessity for a close link with the chest physician which it was thought would be difficult if not impracticable in areas either with a very large and intensively operated service or with widely scattered clinics, unless staff were used full-time on tuberculosis work.

Tuberculosis

36. Generally speaking there was unanimity as to the objectives to be aimed at. All agreed on the importance of the Health Visitor's role in educating patients and families on the nature of the disease, in the management of the patient at home, in the prevention of infection, in tracing contacts and persuading them to be examined, and in overseeing the arrangements for care (housing conditions, garden shelters and so on). The Health Visitor should be able to report on the home circumstances of new patients and in-patients ready for discharge and should be closely associated with the chest physician so that she could be briefed on the clinical aspects of care. The differences of view appeared in discussion of other functions, training and administration.

37. Most witnesses were insistent that no nursing work should be done. Two Scottish bodies however, said that the Health Visitor should do tuberculin tests. The British Tuberculosis Association thought she should read tests on patients at home. One Scottish local authority would have the Health Visitor give streptomycin injections, for example, while other witnesses merely suggested advice to patients and supervision of drug treatment at home.

38. Most witnesses regarded the Health Visitor as the "practical social worker" in the home, recommending and arranging for such services as appeared necessary in the ordinary case. One Scottish body would make her responsible for "co-ordinating" after-care and rehabilitation. The Women Public Health Officers' Association emphasised the value in this work of an almoner—either in the hospital or with the local health authority—with whom the Health Visitor should co-operate. Some witnesses wanted the Health Visitor to link up with the Care Committee at all points. The British Tuberculosis Association, for their part, wanted none of this; the Health Visitor should not do "welfare work" except perhaps to arrange for home helps; she should merely report to the appropriate officer.

39. At clinics, most witnesses felt that the Health Visitor should be occupied solely with consultation with the chest physician or almoner; her function would be primarily that of liaison officer between hospital, family doctor and home. They opposed the permanent attachment of staff to clinics; if local circumstances made this inevitable, they favoured wherever possible, the appointment of Health Visitors whose job would be to keep the general duties Health Visitors informed and to hand over new cases to them either at once or as soon as they were satisfied that this could be done.

40. The British Tuberculosis Association felt that the vital factor was the link between visitor and physician. They wanted wholly specialised staff, permanently based on clinics and without other commitments, carrying out there the normal duties of a hospital out-patient nurse (where these could not be done by a "clinic nurse"). The Association felt that understanding of the family and personal problems associated with the disease and the principles of treatment could come only from a thorough understanding of the disease itself. They would, if necessary, forego the advantages of the Health Visitor training in favour of staff who held the Association's certificate, which all clinic nursing staff should hold. Multipurpose visitors lacked

the necessary clinical knowledge and the time to acquire it or apply it. Other witnesses, on the other hand, were equally insistent that the Health Visitors' qualification was essential to any home visitor and that the preventive attitude and vocational interest were more important than technical nursing proficiency. Essential knowledge should be provided in the training course, revised if necessary.

41. It seemed that controversy over Health Visitors' work was a reflection of a deeper controversy over the functioning of the tuberculosis service. The British Tuberculosis Association appeared to think that the work—admittedly requiring the co-operation of a team—could be effectively done only if centred on the hospital. Local authorities and their staff felt that there was a grave danger that in those circumstances the epidemiological aspects of the disease would increasingly go by default.

School Health Service

42. We addressed three questions specifically to the way in which Health Visitors should work in the School Health Service. We were again concerned with range of work and function and set out in random order for discussion the following general headings :

Attendance at minor ailments and specialist clinics.
Preliminary inspection of children before attendance at medical examinations.
Nurses' surveys and inspections in schools.
Visits to nursery schools and classes.
Attendance at day and residential special schools.
Follow-up home visits.
Infectious diseases control.
Health education (group teaching).

We asked particularly (*a*) what duties (other than home visits) should necessarily be carried out by Health Visitors, (*b*) what duties could be carried out by lay helpers or others with less than the qualifications of a school nurse or Health Visitor and (*c*) what arrangements for liaison should be made where the school nurse and Health Visitor were not the same person.

43. With regard to the first two points, the answers suggested generally that a qualified Health Visitor needed to take part in all activities where the opportunity for discussion with parents and teachers or school doctors occurred and where a review of the children's health would help her and the doctor in caring for the children. She should not undertake work that equally well could be done by others and that did not further those purposes. There were, however, differences of view on how these principles should be put into practice. The Scottish Health Visitors' Association, for example, thought that opportunities of education might occur at any point and no activity should, therefore, be missed. Other witnesses expressed the view merely that the Health Visitor should have the opportunity of attending any activity but should have discretion in selecting her point of influence.

44. Some suggested specific limitations. Minor ailments clinics were singled out by almost all of these witnesses as not needing Health Visiting

staff. Specialist diagnostic and treatment clinics were mentioned by many but some thought attendance would be useful. It was often said that Health Visitors should invariably attend medical examinations and inspections but not all agreed that preliminary inspections by Health Visitors were necessary. She should carry out surveys on her own account, at least annually, which would usually be confined to detecting defects and advising teachers about them, and assessing general health. Opinion was divided on attendance at nursery schools and special schools, depending perhaps on the likelihood that witnesses saw of problems occurring or on the type of staff available at the school to deal with them. Little mention was made of infectious diseases.

45. Health education naturally took priority in every witness's view. A few witnesses suggested that the Health Visitor should co-ordinate health education in schools. The Women Public Health Officers' Association advocated Health Visitors' classes, as part of the local education authority's programme, especially in parentcraft and homecraft. Many wanted Health Visitors to take a more active part in parent-teacher associations.

46. The general view was that much could be done to enliven the work of Health Visitors, increase their effectiveness and economise in skilled staff by allotting to other workers duties such as sight-testing, weighing and measuring, cleanliness inspections and head-cleansing, and treatments. Other staff should undertake receptionist, chaperonage, filing and record duties. Though lay helpers were not strongly welcomed by all, their assistance was thought to be valuable.

47. Some witnesses were at pains to reinforce the importance of the use of qualified staff for home visiting to provide the link between home and school. The Society of Medical Officers of Health wanted the Health Visitor to be the principal link not only with the home but with all outside agencies concerned with school-children.

48. It seems to have been generally assumed that school nursing should and usually could form part of general duties Health Visiting—though it by no means always does so—and answers to the third aspect of our questions were not very specific as a rule. Generally, the obvious answer was given that where the services were not amalgamated the two workers must co-operate closely by whatever method was open to them. Frequent meetings, interchange of information (including notes on hospital discharges and the handicapped) and transfer of child welfare records on entry to school were generally urged. Two employing authorities' organisations recommended that the nursing services of the local health and education authorities should be administered by one chief nursing officer. Another witness recommended the appointment of special co-ordinating officers.

49. Special interest attaches to the evidence of the Association of Education Committees and the Welsh Joint Education Committee, representing local education authority opinion in England and in Wales respectively. The Welsh authorities saw Health Visiting as a single service rooted in maternity and child welfare but providing a service for the family that was available, through the link with the schools, throughout childhood. They strongly supported the principle of the single school nurse/Health Visitor. In the schools the Health Visitor must have time to gain the confidence of both children and teaching staff and doctors and to be an effective link between school and home. If she was to have time for *all* her essential tasks the

inessentials should be removed, though careful supervision of any less qualified substitute would be necessary to avoid the assumption of duties beyond their competence. Their views on the allocation of work did not differ in essentials from those of the majority of witnesses. If general duties work was not done, almost complete exchange of information between the school nurse and Health Visitor was essential.

50. The Association of Education Committees were inclined to emphasise the statutory independence of the School Health Service from the National Health Service and to suggest that the arrangements for the two services should be treated entirely on their separate merits. They saw no essentially new problem in the School Health Service to justify any radical alteration. The employment of school nurses on the business of the local health authority or of the latter's staff on school work was a matter for determination in the light of local advantage; the principle of providing a single Health Visiting service for the whole family was not sufficiently important to outweigh administrative convenience. Within the School Health Service individual duties could not in general be sub-divided between staff according to function. It was, in particular, impracticable to expect Health Visitors to follow-up cases they had not themselves seen. Exceptions might be made for weighing, measuring, sight testing, audiometric survey, cleanliness inspections and cleansing, and work in minor ailments, specialist and ultra violet ray clinics. Liaison between separate workers was admittedly difficult in urban areas. Exchange of information about defects in infancy or arising during school life was difficult but might become routine. Liaison would be eased if Health Visitors could visit school clinics for discussion.

Combined Duties

51. The arrangement by which Health Visitors act also as home nurses or midwives or both is described in many areas as "generalised duties". We have preferred to use the term *combined duties* throughout this Report. (Where we refer to *general duties,* we mean the practice of the whole accepted range of Health Visiting by one worker, that is, maternity and child welfare, tuberculosis and school health services and associated work.)

52. The question whether these duties ought to be carried out by one person proved, as expected, to be highly controversial—opposite views being expressed by the Queen's Institute of District Nursing and some Scottish opinion on the one hand, and on the other hand by all other witnesses, in principle at least. With the exception of the Queen's Institute, the Scottish County Councils Association and, with reservations, the Convention of Royal Burghs, no witnesses were prepared to favour combination and would admit only that it might be expedient in rural areas on grounds of economy. Even in such areas some witnesses were insistent that all staff should be fully trained. (This is a point of some significance for it is in the areas where combination is practised that, on the whole, the largest number of "acting" Health Visitors is found.) The Royal College of Nursing, however, with the Association of Municipal Corporations, and the British Medical Association would be prepared to see objective practical experiments in urban areas to demonstrate the merits or demerits of combination.

53. Those who argued against combined duties asserted that curative and preventive or educative attitudes were psychologically incompatible; the type

of person whose main interest was nursing the sick was rarely also deeply interested in teaching preventive measures. The practising sick nurse was more concerned with the individual and less willing or able to consider family relationships. She worked under the direction of a doctor and became less accustomed to the independence needed by a Health Visitor. The home nurse/midwife was too closely associated with the social life of her area to be the confidante of the family in any really fundamental problem ; a more detached figure was needed. Two of the professional Health Visitor organisations preferred the Health Visitor to live outside her area for this reason. One organisation added that the nurse's uniform itself lent an air of "authority" that inhibited confidences—and, too, created the wrong impression in conference with social workers.

More from an administrative point of view, it was asserted that the unavoidable commitments of home nursing—at all hours—prevented staff from keeping fixed appointments (such as clinics), made the timing of advice difficult and left inadequate time for sympathetic listening. Home nursing and midwifery made such demands on staff that it was unfair to expect them to do Health Visiting as well. Moreover, in the towns at least the demands made on home nurses were increasing. For all these reasons, Health Visiting would come off third best to the detriment of the service—and of the profession. To these arguments might be added the problem of recruitment and training. All the services had to be provided in any case ; even if matters could be so arranged that combined duties were practicable, there would never be enough people who were capable of providing a fully effective combined service in all areas.

54. The Queen's Institute, in particular, strongly refuted these arguments. It was not true that a well trained home nurse with the Health Visitor Certificate could not equally well be a successful educator and family visitor, acting as a general social worker in co-operation with specialists. She must have an area small enough to operate successfully in all three roles—1,000 to 2,000 population. The difficulties outlined by the proponents of full-time Health Visiting then disappeared. Indeed the "family nurse" had the advantage of a much stronger emotional link with the family, whom she would have attended in sickness (with its admirable opportunities for education) and during the peculiarly receptive phase of pregnancy and child-birth. Her detailed knowledge of local affairs could make her advice both more timely and more apt. The fact that she was a practising nurse and midwife and had the key to family confidence made her all the more acceptable to the general practitioner. In rural areas, combination was inevitable because of time and distance alone. The Scottish Counties for the most part thought combination the only economical and efficient way of providing an adequate service in rural areas. The Queen's Institute thought that it might not be easy to achieve in the towns the manpower economies that were effected by combination in the country but that nevertheless experiments in urban areas would be worthwhile.

The Health Visitor and General Practice

55. All our witnesses welcomed a closer association between Health Visitors and the family doctor and some thought it vital if the service was to develop. The British Medical Association, for example, saw in the linking up of

services a reflection of the essential complementary and supplementary relationship between the medical officer of health and the general practitioner representing respectively the preventive and curative aspects of family medical services. The Health Visiting Service was one of the medical officer of health's responsibilities; his overriding authority must be respected and the calls on the Health Visitor's time made by work on his behalf must be recognised. Arrangements would no doubt vary with local circumstances. Subject to that, the work of Health Visitors with family doctors was seen as a direct and close working relationship in which there would be a free mutual exchange of information and mutual support. Doctors would no doubt rely on Health Visitors' advice on matters affecting social conditions and the provision of services and would need to recognise that their functions did not include sick nursing; they would support their work in their own contacts with a family, would call on them for information about the home and discuss common problems. Health Visitors would expect to accept the clinical decisions of doctors and to reinforce these in the course of their visits, whether incidentally or while directly following-up cases at the request of the doctor. Health Visitors would encourage patients who were clearly in need of medical advice to consult their doctor at an early stage; this would not in the end increase his work and, indeed the help Health Visitors could give might tend to reduce the burden on the doctor. The Health Visitor's own work load might well increase at first but in the end the doctor's support should more than counterbalance the increase.

56. In considering the range of work of Health Visitors generally, the British Medical Association thought special attention should be paid to the following subjects presumably because they were of greater interest to general practitioners:

Mothers and babies.
Children under both hospital and general practitioner supervision (e.g. diabetics).
Convalescent adults.
Chronic illness.
The elderly and infirm.
Tuberculous patients.
Accident prevention in the home.

57. The number of individual points made by others almost equalled the number of witnesses. They overlapped the suggestions made above, the most popular being those dealing with the care of mothers and children (of all ages and conditions), after-care of convalescents in a broad sense, care of the aged and infirm, supervision of families living in unsatisfactory social conditions and arrangements for services to be provided. One or two would go so far as to suggest that the Health Visitor could help over the whole range of practice, except for nursing and midwifery duties. Among the subjects which few specially mentioned were infectious diseases and tuberculosis. The latter omission perhaps reflects the extent to which, in practice, care now centres on the hospitals.

58. No witness was able to report that co-operation was already extensive. Rather it was in its infancy but developing reasonably well. It was apparent that combined workers had a well established relationship with doctors in

rural areas but whether this depended on their nursing function or their Health Visiting function was not clear. Many witnesses said that younger doctors tended to be more appreciative of the possibilities of preventive work.

59. A most important contribution was made early in 1954 by the British Medical Association jointly with the Society of Medical Officers of Health. The Association put in evidence a circular sent by themselves and the Society to local medical committees inviting the help of all general practitioners. They put forward the following principles:

1. Co-operation between general practitioners and the medical officer of health and his staff was essential to the well being of patients; close association of the whole as one team was necessary to fulfil responsibilities.
2. The public health duties of the Health Visitor did not prevent her from assisting in the care of individuals under the guidance of the general practitioner.
3. General practitioners and Health Visitors should consult directly and exchange information.

Urging strongly that discussions should take place as to the best way of realising these objectives in differing local conditions the circular suggested:

1. Discussions between medical officers of health, their senior staff, branches of the Association and local medical committees.
2. Personal discussions between practitioners and Health Visitors serving the area of their practice.
3. Consultation on cases to avoid the possibility of conflicting advice.
4. While Health Visitors should be available to visit the practitioners' patients on request, there should be full consultation between the parties to ensure the efficient and economic use of Health Visitors.
5. Circulation of detailed information to general practitioners about services available in the area, so that the right kind of help could be asked for at once, the best use made of the Health Visitors' services and repeated visits by practitioners avoided.
6. Allocation of Health Visitors to groups of practitioners as far as possible.

The Association reported, when giving oral evidence, that a large number of local meetings had already been held and they were confident that a rapid growth of co-operation would result, once some local arrangement was established.

60. Witnesses welcomed the initiative taken by the Association and the Society. Many of those most closely concerned thought that progress would be faster if practical experience of co-operation was given to medical students. Clearly if general practitioners themselves took part in the maternity and child welfare services co-operation would be easiest. If no natural focal point, such as a clinic or health centre existed, Health Visitors should nevertheless have some known base to work from, where direct contact could be made (though two witnesses were doubtful whether communication otherwise than through the public health department was entirely wise). If possible, telephones—the simplest means of communication—should be provided.

Great difficulty was likely in areas where many practices overlapped and the Health Visitor's own district could not always be suitably adjusted. General practitioners ought to have up-to-date lists of Health Visitors to whom they could refer. When personal contacts were made on a social or professional basis, experience showed that difficulties disappeared; but the measures recommended depended in the last analysis on goodwill on both sides and a positive effort to meet colleagues half-way.

The Health Visitor and the Hospitals

61. The evidence generally indicated a genuine desire on the part of local authorities and their staffs to play a helpful part in the hospital care and after-care of patients of all classes. It also reflected discontent at the alleged tendency of hospitals to "introversion". On the one hand the hospitals appeared to be criticised because local authorities were insufficiently informed of matters affecting patients with whom their staff were concerned; on the other hand it was thought that some hospitals were inclined to wish to play too great a part in after-care—properly the concern of local authorities.

62. It is interesting to note that consultant opinion, expressed through the British Medical Association, asserted that the proper channel of communication as a matter of principle lay between the consultant and general practitioner but that in practice on non-clinical matters it would usually be more convenient to work through the almoner's liaison with the Health Visitor, representing the local health services. The Institute of Almoners supported this view and strongly urged closer personal contact between Health Visitors and almoners.

63. Generally witnesses took the view that the public health or the school health department should be notified of discharges in agreed classes of case. At least they should be told the names of patients and dates of discharge; at best they should have a copy of the discharge letter to the general practitioner. It was urgent that notification should go out promptly to both and preferably before discharge; hospitals were often at fault in this respect. Most witnesses wanted Health Visitors to be in direct touch with the almoner and some with the ward-sister. A few wanted them to work directly with the consultant at case conferences or ward rounds in certain cases. Some wanted after-care to be actually arranged in consultation between Health Visitor and general practitioner and a few would be content with this alone. Where all Health Visitors could not be directly in touch with the hospital, arrangements must be made to keep them informed about patients from their districts. A "link" Health Visitor should be responsible for this. It was thought that special arrangements of this kind were particularly necessary in the case of tuberculosis and maternity and paediatric wards. The Royal Sanitary Association recommended that notification should extend to out-patient attendances of children, as it did successfully at one Scottish hospital. One witness urged that Health Visitors should make themselves familiar with the infant feeding technique and teaching of local hospitals. Other witnesses were keen to see mothercraft and parentcraft classes run in association with hospital ante-natal clinics.

64. Some witnesses referred to the development of arrangements for following-up after discharge patients with diseases where long term supervision might be needed or a strict regimen was prescribed, for example,

cardiac and peptic disorders and diabetes. They recommended the extension of this type of work to geriatrics, orthopaedics, rheumatic illnesses and various classes of permanent handicap, especially among children. Many felt, however, that in all classes of illness where after-care measures were needed or illness raised serious family problems the Health Visitor might come to play a larger part. All felt that the Health Visitor could, as required, supply valuable information about the social justification for priority of admission to limited beds (for example in the case of maternity bookings, where the midwife did not do this) and could advise perhaps on the timing of discharge or on family difficulties likely to affect the recovery of patients. It would be helpful to both relatives and patients if she could visit the latter in hospital. She must have early warning of discharge to be of most value. She could then make preparation for the patient's return home, arrange for equipment or the provision of home help (where necessary) and advise the family on future management of the case.

65. The reservation was made by the Royal College of Midwives that, in the case of discharges from maternity hospitals, responsibility should rest with the domiciliary midwife until twenty-eight days after the birth. The Central Midwives Boards also would prefer the domiciliary midwife to take over until the twenty-eighth day, despite the double handover involved.

The Health Visitor and Family Welfare

66. One of the factors to be reckoned with in the claim that Section 24, National Health Service Act, 1946, gives to Health Visitors the role of general purpose family visitor is the existence of other workers who also feel bound to take account of total family needs. We, therefore, asked to what extent " overlapping " and duplication of effort existed in the provision of social services for families with which the Health Visitor was concerned. We also asked how far this could be avoided by administrative measures and in particular by the creation of an all-purpose " family visitor ", acting so far as was thought practicable as a co-ordinator of health and welfare services.

67. Opinions varied as to the extent of multiple visiting and its effects. It appeared to present no particular problem in rural areas. The Queen's Institute of District Nursing, for example, thought it was confined to the big cities and mostly to " problem families ". They were more inclined to stress the overlapping of nurses, midwives and Health Visitors, though the Society of Medical Officers of Health said this did not occur because of unitary administration. In the cities, difficulty was said to arise through division of administrative responsibility and the establishment of new groups of staff with special interests not only by local authority departments but by hospitals and voluntary bodies. Some witnesses distinguished overlap arising naturally from differences of function between Health Visitors and case-work specialists on the one hand and on the other hand artificial overlapping, where workers of about the same general level of capacity, training and experience were performing broadly similar functions with the same families without co-ordination. Such workers could easily frustrate each other's efforts and between them bring little benefit and perhaps harm to the family concerned, if they did not work together. Some thought the problem serious, but most

thought its extent exaggerated, taking the whole field of work into consideration.(1)

68. Within the health department, multiple visiting occurred both in tuberculosis and in mental health work. Health department workers, however, might overlap with the education department (child guidance workers, education welfare officers), welfare department (especially the care of the handicapped), housing department (rehabilitation work on new estates) and the children's department (supervision of neglected, adopted and boarded out children). References were also made to government departments such as the National Assistance Board and to voluntary bodies such as the N.S.P.C.C. and moral welfare organisations. This list is not of course exhaustive; many workers have drawn up impressive lists of different types of visitor who, even in rural areas, may and sometimes do become collectively an additional misfortune for the unfortunate. Our evidence would only add one possibility to the collection—still only a small cloud on the horizon; one witness advocated the addition of the factory doctor and presumably therefore the industrial nurse to any local co-ordinating group.

69. A few witnesses favoured the appointment of one chief officer to control all services as at least a partial solution to overlapping. A few advocated the appointment of special co-ordinating officers. So far as Health Visiting was concerned the amalgamation of as many jobs as possible was recommended. One witness suggested the formation in each local authority of a central register of families, embodying central but non-confidential information which would be available to workers from any department. Others recommended full exchange of information, within ethical limits, between workers or departments. Most seem to have favoured the wider use of case conferences and of co-ordinating committees on the pattern of those set up, with much success it was said, by many authorities to deal with "problem families". Such committees might exist both at headquarters and for smaller areas and should be widely representative.

70. Many witnesses suggested that further extension of the number of types of social worker with a limited field should be avoided wherever possible in order to simplify consultation. The ideal solution would obviously be an "all-purpose" visitor. The London County Council and the Association of Education Committees joined with the case-worker group and Universities in doubting whether any single worker could possibly deal with all the multifarious family health and social problems arising in modern conditions. All these problems might face a visitor covering a wide range of families but their solution would demand widely different qualities of skill and virtual omniscience about the practical working of the social services. The London County Council especially mentioned the influence of existing local circumstances on any such administrative and staffing policy.

71. The Joint Universities Council for Social Studies and Public Administration agreed that there might be a place for a general family visitor able to deal with simple problems within a recognised boundary and to call on the appropriate expert when needed. Though the Health Visitor did not, of course, cover all families, she was better placed than most to undertake this role, if appropriately trained. A decision on primary function was

(1) cf. Wofinden, R. C. (1954) "A Note on Multiplicity of Home Visiting by Medico-Social Workers". Med. Officer *91*, 83.

necessary, for the term "family visitor" could be used in many senses. For example, the visitor might be of the "friendly, good neighbour" type who, besides exercising any specialist functions, would attempt little more than immediate practical help and would refer difficulties to an appropriate authority; or a general family case-worker, like those employed by the Family Welfare Association; or an exceptionally well-qualified worker able to co-ordinate and supervise a team and act as consultant in difficult cases. Within the Council's limited experience, Health Visitors were not yet prepared for any but the first role and, even so, they were too inclined to concentrate on their own purposes and to underestimate or pass by problems of a deep seated nature or problems affecting persons other than the individual with whom they were concerned. Their necessarily heavy case-loads indeed made any other approach difficult.

72. Witnesses from the case-worker group, especially the Institute of Almoners, dwelt at length on contrasts between the functions of the multi-purpose visitor of the first of the three types described by the Joint University Council and those of the professionally trained case-worker. The obvious practical differences lay in the widely different incidence of the problems with which both had to deal (and therefore the case-loads that both could accept) and the fact that acute social problems could not all be approached in the same way or by the same person, however expert. While the family visitor and the professional case-worker each could claim to have full respect for the integrity of their clients, their general approach to a problem was necessarily different. The former, in a large part of her work, pursued a clearly defined objective, using instruction, persuasion or direction, or whatever means seemed most likely to achieve the end thought to be desirable for the client. In this role she was welcomed by the client who was conscious of his need for expert advice. The professional case worker on the other hand, was increasingly having to deal with clients unable to use direct advice, however expert, until their anxieties had been relieved by talking out their problems within the security of a professional relationship with the case worker. The aim of such a relationship was to give the client the understanding and support needed to enable him to find a solution which was related to his personal needs and values rather than to those of the worker. The case worker's aim was to help him to use his own strengths in order to become fully self-directing as soon as possible.

73. The value of the general purpose family visitor lay in the wide range of families covered but this in itself was a tactical disadvantage in a case-work situation. If a wide range of families and problems had to be covered, even selectively, there could seldom be sufficient time for close analysis. More important, the family visitor—constantly in her district among many families, perhaps constantly with the afflicted family—might be a too familiar figure to be the consultant of choice in more complex or intimate problems. Many people might prefer to seek advice on such problems from a more remote professional worker from whom they could dissociate themselves after the particular problem had been solved or their own capacity to deal with it sufficiently strengthened. This was not to suggest that one form of work was socially more valuable than the other; on the contrary they were complementary. Each worker would refer to the other freely and each had much to contribute to the other. None of the professional case-worker group saw

any insuperable ethical difficulty in the exchange of information within services with a common aim, provided it was fully understood that disclosure must never be made directly or implicitly (in action taken, for example) to the client or those concerned with him. This matter should be dealt with in practical training.

74. It was not at all clear how far this point of view was acceptable to most other witnesses. The evidence relating to the functions of the Health Visitor in mental illness tended to suggest that the non-clinical aspects of the work of the psychiatric social worker were well understood. The evidence of the Royal College of Nursing and Women Public Health Officers' Association, among others, suggested that the intervention of specialist professional case-workers could not be regarded as true overlapping. Criticism of the extra-hospital activities of the almoner—which took no account of the increasing employment of almoners by local authorities—may have been in fact intended to relate only to activities that were thought to be as well or better done by Health Visitors. The usefulness of other workers less well-established and perhaps less well trained was apparently questioned by many. The Society of Medical Officers of Health in their oral evidence clearly indicated that the function of the "all-purpose" visitor was to relieve the burden on scarce professional case-workers by co-operative effort; she might come to supersede on the other hand the social worker without proper professional training or highly specialised task who brought to the work only a social science diploma or merely good intentions, without the background of experience of practical work with people that the Health Visitor's early training gave her.

75. It was clear enough that many witnesses, especially the employing authorities, thought the Health Visitor should occupy a central position as the principal home visitor in the health services and that she could do a wider range of work extending beyond the administrative responsibilities of the health and education authorities. Descriptions of the kind of work she would do were however not very precise and in some instances may have carried implications that were not fully intended.

76. One employing authorities' organisation, for example, would impose on Health Visitors the function of *co-ordinating* "all agencies operating for the promotion of health and social welfare in the home, . . . consulting wherever necessary, other agencies concerned". They viewed her work as essentially "practical", without, however, describing this term or its antithesis with any precision. Supporting this view generally, another made the reservation that "co-ordination" should not imply "administrative" duties. Noting that the trend of need was towards the solution of social and psychological problems and away from questions of purely physical health, Scottish authorities' representatives described the Health Visitor as the primary health and social worker, an area worker implementing local authority policy; one body used such phrases as "friend" and "impartial and detached adviser" and "sympathetic confidante" to describe her way of working. The Women Public Health Officers' Association suggested that the Health Visitor's co-operative role was partly that of "tutor", interpreting to families the work of specialists and supporting their approach. The Queen's Institute of District Nursing, recognising the need for specialist help, described the Health Visitor's function as "group teacher and individual consultant adviser to mothers regarding the upbringing of their families; health adviser to school children, to deal with

deviations from the normal; and to be medico-social worker, coping with family problems at home or at clinics". The Standing Conference of Health Visitor Training Centres laid particular stress on the recognition of incipient problems, whether social, psychological or physical in origin, and on ability to give "first aid". Concentration on the needs as a whole of mothers and young children should be the basis of a "family visitor's" work. The Society of Medical Officers of Health, while agreeing on this point, emphasised that in the course of her visits for this and other purposes the Health Visitor must give "advice and health education on any medico-social problem". The general function might be summed up as "teaching and guiding of individuals and families to become physically and mentally healthier by their own efforts, to accept their family responsibilities and to fit in with the community of which they are a part". This definition, of course, goes very close, to say the least, to the boundary suggested by the case-workers.

Qualifications for Entry to Training

77. Witnesses in all groups except the social welfare and case-worker interests were unanimous that qualification as a registered general nurse was essential.(1) The reasons for this were stated in a number of ways which can be considered more conveniently in a later chapter. Briefly, they were that the training made an essential contribution to the Health Visitor's professional expertise and her prestige with the public, nurses, midwives, social workers and doctors, and it enabled her to seek other employment if Health Visiting failed her. Most witnesses in these groups supported with varying degrees of emphasis the proposal of the Nurses' Working Party(2) that formal nurse training for state registration as a nurse should be possible in two years. Reference was also made to additions made by the English and Scottish General Nursing Councils to the nurse-training syllabus to enable students to gain a better insight into the background of hospital patients and into the local health services. This was generally welcomed as a contribution to the education of potential Health Visitors.

78. Of the social welfare group the Society of Mental Welfare Workers accepted fully that the Health Visitor should be a nurse but argued, by implication, that this in itself gave good grounds for excluding her from social work with the mentally ill and defective, which called for a different fundamental attitude and non-nursing training. With varying degrees of emphasis all the social welfare and case-work interests and the witnesses from University departments took the point that nurse-training and experience inculcated habits of mind that made conversion to the social science outlook exceedingly difficult. Nurse-trained Health Visitors were, for example, inclined to be didactic in situations where such an attitude was unsuitable and to advocate ready-made solutions that while sensible in themselves did not pay full enough regard to the views of the client or his less obvious needs. This was, of course, true of other professions besides nursing. These objections would have greater force if Health Visitors entered to a greater extent fields

(1) We use the terms "registered general nurse" or "general nurse" throughout as a matter of convenience to describe State Registered Nurses (S.R.N.) in England and Wales and Registered General Nurses (R.G.N.) in Scotland. In suitable contexts, the term "nurse" only is used.

(2) Report of the Working Party on the Recruitment and Training of Nurses (1947), H.M.S.O.

of work where a case-work approach was essential. Some other witnesses, including Health Visitor organisations, were in fact, inclined to agree that many nurses did have difficulty in adjusting themselves to social and public health training courses.

79. The solution suggested by the Association of Psychiatric Social Workers was a reversal of the order of the trainings—a two year social science course followed by a purposive health training. The Institute of Almoners on the other hand agreed with the Society of Medical Officers of Health that such a reversal was unlikely to be successful. Faced with a hospital training, many students would use the social science training they had gained to take up some other form of work. The Standing Conference of Health Visitor Training Centres opposed such an arrangement on the same grounds on which it was proposed, namely, that the earliest professional training to some degree informs all later training and experience.

80. There was rather more diversity of opinion as to the extent to which Health Visitors needed midwifery training. One view was that without the full midwifery qualification the Health Visitor could not carry out her statutory function of giving advice to expectant mothers. Another, expressed for example by the Scottish Health Visitors Association, was that since most Health Visitors in Scotland had to practise midwifery—and others might wish to later—they should not be deprived of the opportunity of qualifying. Midwifery was a useful second profession if Health Visiting failed and the qualification was an advantage to candidates for promotion. The Women Public Health Officers' Association pointed out that domiciliary midwifery training was the first step in re-orientation towards preventive attitudes and the stage at which many Health Visitors were recruited. An obstetric training was unsatisfactory if it led only to Health Visiting and did not lead to the state certificate eventually. Few witnesses thought Part I of the certificate really useful alone since it was concerned with hospital work only and therefore to a large extent with abnormal conditions. Some would prefer a revised training in which hospital and domiciliary training were combined. Some witnesses would support a special course of obstetrics, if it were decided that Health Visitors should not practise midwifery, to enable the Health Visitor to co-operate successfully with the midwife. Others thought the present requirement—Part I of the state certificate—should continue until it was possible to include a period of specialised maternity training, including domiciliary aspects, in a shortened nurse-training course. Among those who favoured a short ad hoc training suitable for full-time Health Visitors was the Queen's Institute of District Nursing who sent us a most interesting draft scheme for a four months' course.

81. Views on the possibility of courses for nurses intending to become combined workers largely reflected views on combined work. Some found such courses impracticable, others undesirable. If combined work found favour, some thought the courses now run by the Queen's Institute of District Nursing would be suitable. (The Institute's approved Health Visitors' courses are immediately followed by district nurses' courses reduced to three months' length. Students may take both courses or the Health Visitors' course alone.)

82. The age at which entry to Health Visitor training should occur was generally placed at about the age at which nursing and maternity training would normally finish. The general view was that mature development

was more important than physical age. Some pointed to the dangers of too long a gap between trainings ; others thought such a gap—used to acquire relevant experience—might be invaluable but the minimum age should be not higher than 25 years. Relevant interim experience might include practical work with healthy children, or experience in children's, tuberculosis or infectious diseases wards. No maximum age was thought desirable.

83. Generally witnesses were concerned that students should have, besides suitable personal qualities, a satisfactory educational background. Though a minimum educational level should not be insisted on to the exclusion of otherwise suitable candidates, a standard should be aimed at. Most witnesses suggested the general certificate of education or Scottish leaving certificate. The Scottish branch of the Society of Medical Officers of Health thought University entrance standard should be the aim. Asserting that higher standards should be set and that these might soon be attained, the Women Public Health Officers' Association suggested that students should have the general certificate of education at the ordinary level in at least five subjects. The London County Council thought that at least two subjects should have been taken at the advanced level—English and either social history or a general scientific subject.

84. A good system of selection is implied in the suggestion that other criteria of suitability might be alternatives to a recognised educational standard. The Standing Conference of Health Visitor Training Centres recommended that there should be a recognised standard of selection enforced by the training centres (as, in practice, in Scotland) and not by the sponsoring authorities. References should be taken up, there should be a medical examination, a simple qualifying test of command of English and general knowledge followed by an interview by a broadly constituted selection committee to test personal qualities.

85. It is relevant to note here the requirements of Universities for entry to the basic social science course. We were informed that students would normally be accepted at a minimum age of 19 years and would be selected for intellectual fitness for University work as well as personal suitability. (The standard might be the general certificate of education at advanced level in a number of subjects.) It was common to insist on a year's working experience between school and University to give students a chance to experience the stresses of normal life and to meet a wide variety of people. A further year of professional training was increasingly recognised as necessary, either specialised, or, as some now hoped, generic in character.

The Professional Training of Health Visitors

86. The employing authorities, professional groups and training authorities all expressed satisfaction in very general terms with the ground covered by the present syllabus of training, though there were many reservations on the part of some of them. Generally the accent was on a longer training of a less crammed nature, taken at a more leisurely pace and with a larger proportion of supervised practical experience. A number of witnesses thought those parts of the syllabus that had already been covered in nursing or midwifery training could well be omitted. The Standing Conference of Health Visitor Training Centres thought the omissions might extend to the public

health sections of the syllabus when the revised General Nursing Council syllabus (Part XI) was fully implemented. Scottish witnesses, particularly, wanted the content of sanitary and environmental health subjects reduced.

87. There were a number of proposals for improving the content of the training. The emphasis placed on many suggestions depended on the witnesses' views on functions. For example the London County Council thought that, in the case of venereal diseases, mental illness, marriage guidance, moral welfare, special educational services and the care of the aged, blind and handicapped, Health Visitors need be trained only to recognise the need for reference to and co-operation with the more expert workers who ought to be responsible for work in these fields. Other witnesses placed the accent on practical ability to handle a wide variety of cases, especially the care of the aged. Almost all were agreed that greater attention must be paid to the "social work" aspects of visiting—in proportion to the extent that the balance of the work should be tilted in that direction. A number of witnesses advocated the strengthening of the section in the syllabus on social economics with special reference to illness and disability. Subjects bearing on this topic that were specially mentioned included the care of the tuberculous, the aged and the handicapped, and household management generally (including nutrition, budgeting and accident prevention).

88. Great attention was paid to "mental health" or "mental hygiene" which was almost unanimously accepted as a matter on which Health Visitors' training should concentrate. The subject was so consistently mentioned and often so carefully distinguished from others as almost to appear a separate and definite duty, though it defied precise description. The Society of Medical Officers of Health noted that emotional illness was increasing, and that success in the public health field depended increasingly on securing the acquiescence of the public in measures for their personal benefit and therefore on understanding the emotional reactions and attitudes of individuals and family groups. They advocated, therefore, such training in the principles of psychology as would help the Health Visitor in assessing child development and coping with problems of relationships, especially of the mother and child, and mental adjustment to new situations. The student should have the opportunity to study the development of normal children and she would be helped also by attachment to a child guidance clinic. The Scottish Branch of the Society and the Association of County Councils of Scotland added the special point that "mental health" training should deal particularly with the needs of the aged. The Standing Conference of Health Visitor Training Centres were doubtful how centres would be able to deal with this aspect of training.

89. Many witnesses advocated a more thorough approach to training for the work now generally recognised as being in the Health Visitor's province. Students should have careful training in the techniques of approach to people of different kinds in different circumstances and of successful interviewing. There was a fairly general demand for training in health education techniques in dealing both with groups and with individuals. (A few witnesses thought group teaching a specialist function requiring extra training.) It is probably fair to say that all witnesses were concerned that students should have a fuller knowledge of the work of other social agencies, insight into their objectives and methods, and training in the art of referring cases and

co-operating in a joint approach to a common problem. Students should have a better training in case-reporting and record keeping. Practical work should be taken in areas better suited for the purpose, should be better and more comprehensively planned and supervised and should be related to studies. The overriding reservation implicit in much of the evidence but expressed forcibly by the Association of Municipal Corporations and the Royal Society for the Promotion of Health was that the Health Visitor must be a " practical " worker who therefore needs a practical training.

90. Witnesses representing the case worker interests and University Departments were in general agreement with the trend of the views outlined above but they would go further in the direction of training for the social aspects of the work. The Association of Psychiatric Social Workers stressed that experience was no substitute for basic formal and technical training. They thought it important that the Health Visitor's course should lay emphasis on an understanding of the relationship between the mother, her children and the rest of the family ; the normal development of children and the emotional aspects of stages of that development (mentioning specially feeding, sleeping and toilet training). They referred also to the psychological problems surrounding the sick and the aged. The Institute of Almoners warned against overloading the course with sociology—stress should fall on practical knowledge of social agencies and instruction in the techniques of interviewing, educating and case-reporting. The Association of Children's Officers, noting the higher standards of co-operation of more recently trained Health Visitors, suggested that still more training was needed in the recognition of incipient problems and an assessment of when and how to refer them ; insight into family problems and knowledge of other workers' fields—not least that of the child care officer—was necessary for this. The Joint Universities Council and Hull University concurred generally in these views but expressed doubts about the capacity of any student to cope with the task set in less than the period normally needed for a social science diploma.

The Form and Organisation of Training

91. Both the length and the nature of courses came under criticism. The shortest period recommended by any witnesses was one academic year—equivalent to nine months training—but some witnesses thought a full calendar year desirable. The Society of Medical Officers of Health strongly urged a training of eighteen months, but this was linked to the introduction of a shorter nurse training. The case worker group advocated a social science course of about two years with a " health worker " training of about the same length, balanced in duration, that is, according to the relative importance of the two sides of future work. The Association of Psychiatric Social Workers would like training to be associated with that of other social workers. In any event, uniformity of practice was essential. The quality of the courses, it was thought generally, could be improved. They were too hurried, too crammed ; there was a need for better quality teaching, since the influence of the tutor was felt for many years. Discussions, seminars and practical case conferences should bulk large. Practical work needed to be better organised and related more closely to theoretical instruction. No more than one student should be given to one supervisor of practical work and the ratio of students doing practical work to total Health Visiting staff should not exceed one to four.

Some witnesses thought that course records should weigh with the examiners perhaps more than the examination.

92. While one or two witnesses strongly doubted whether a University link with training was either suitable or desirable for Health Visitors, most wanted an association of some kind, partly because of the practical advantages of attachment to a superior educational organisation and of a closer link with medical schools or social studies' departments, but partly also because of the more favourable status resulting for Health Visitors, especially in relation to social workers. Some, such as the Standing Conference of Health Visitor Training Centres and London County Council, wanted the training to be conducted by a University department or technical college affiliated thereto. Others preferred that the Universities' influence should be exerted through membership of a central body responsible for the organisation of training. Employing authorities and the Society of Medical Officers of Health stated or implied that control of courses should remain with local authorities, if indeed, they were not wholly responsible for them.

93. Views on central organisation varied. The Queen's Institute of District Nursing saw the problem as one of co-ordinating nurse and midwifery trainings. Scottish witnesses generally saw no objection to the present arrangements, except that the examining body should be more broadly representative of employing, professional and educational interests. Some English witnesses were inclined to agree, the English employers tending to claim that the local authorities as such should have a voice. But some uneasiness as to the flexibility of present arrangements was expressed by many. While the conduct of examinations might well remain in the hands of the Royal Society for the Promotion of Health it was thought the control of the syllabus and supervision of the curriculum should be undertaken by a more widely representative body. This would be essential if Universities played a full part in training. Indeed the Standing Conference of Health Visitor Training Centres, the Royal College of Nursing and the London County Council joined in looking to a time when University training centres would control their own courses and internal examinations and issue their own certificate of qualification. Most witnesses, however, preferred a certificate of competency granted by a central training body, while some advocated a national register (which might include a separate part for tutors) to be kept by the professional bodies, the examining body or, some said, the General Nursing Council. The object of the register was said to be partly to enforce standards and impose discipline and partly (perhaps mostly) to enhance status. No suggestions were offered as to how the cost might be met.

94. Witnesses' views on the extent to which Government departments should intervene to help to maintain standards were coloured by a natural desire for independence of any central control. Those local authorities who advocated special financial aid for training thought that some element of Government supervision would necessarily follow but they saw in this the advantage that uniformity of arrangements not only in the training itself but in the finance of training could thus—perhaps only thus—be achieved. Some bitterness was shown at the failure of many authorities to pay their share of the cost of training, while benefiting from the expenditure of others. Some Scottish authorities favoured the extension to Scotland of the Statutory

Instrument(1) in force in England and Wales requiring Health Visitors to be professionally qualified; they hoped that this would result, as in England and Wales, in a reduction in the number of unqualified workers. The professional organisations saw in Government backing an essential safeguard to their interests even if it only took the form of membership of a central training body.

Recruitment Problems

95. Most witnesses referred to a real shortage of Health Visitors in almost all areas. Many witnesses referred to the general shortage of women available for employment according to the estimates made by the Ministry of Labour and National Service and suggested that inevitably recruitment to Health Visiting would suffer. There was a special shortage of women of the level of ability required for Health Visiting and this was accentuated by over-specialisation—as between Health Visitors and social workers, or, as the Queen's Institute of District Nursing suggested, between Health Visitors and nurses. Co-ordination of work would help in that respect, either administratively by combining health and welfare departments, or functionally by securing better co-operation and eliminating unnecessary jobs.

96. The overall length of training—from student nurse on—was mentioned as an obstacle by some; this could be reduced only by shortening nurse training. The London County Council pointed out that recruits had now first to do nursing and midwifery courses before taking up the final training, but some girls would prefer to embark on a Health Visitor training straight-away. There was no uniformity of training grants, according to a few, who added that grants were often not commensurate with needs at the age when training was taken. Grants were often conditional on a contract of service after training. This deterred recruits who wished to be free to offer their services anywhere. It failed in its object unless the authority's area could be made attractive on the long term. The training courses in themselves were not always attractive to those who sought work of truly professional status; better courses would stimulate recruitment.

Publicity was needed to attract especially the nurse but also the school leaver. The functions of the Health Visitor were largely unknown to the public, to doctors and to nurses; all the emphasis of recruitment drives lay on the attractions of curative work to the exclusion of prevention. Measures to familiarise general practitioners, medical students and student nurses with public health work were welcome and should be intensified.

97. By far the most important deterrents were said to be the pay and conditions of service of Health Visitors compared with those of other workers. Some witnesses pointed to disparity between conditions of work in hospital and home nursing generally and in Health Visiting, and others made comparisons with the non-graduate teacher and certain social workers; the Royal College of Nursing supplied a list of workers with more favourable conditions but no better claims (according to the College) to professional status. Generally the comparison was made with the ward-sister living in hospital whose salary was slightly higher than the Health Visitor's, whose basic training was shorter, but whose situation—making all allowance for

(1) Statutory Instrument 1948, No. 1415.

variable living conditions and liability to duty—was markedly more favourable; it was this level of ability that was tapped to recruit Health Visitors. Conditions of service—holidays, sick leave and so on—were also said to be inferior to other workers' and in need of improvement. A well-designed national uniform would itself be an attraction, according to two witnesses. Opportunities for advancement were few. The number of senior posts had decreased with the transfer of work from district councils to the Counties. Nothing lay between the administrative posts and the general duties grade except certain posts carrying added responsibility allowances and the Health Visitor tutor posts, which involved further training and in any case were open to few. Higher scales for more experienced staff, "area" posts (of an administrative or consultant character) and special allowances for certain specialists, such as group teachers, and for staff acting as practical tutors to students, lecturing to students, etc. were all suggested. Differential scales for areas where conditions were unavoidably unattractive were also recommended.

98. Part of the shortage would be made good by re-organisation. The need to reduce the time spent by Health Visitors in travelling was strongly pressed. The employers' representatives as well as medical officers and professional organisations were all insistent on this point, to which some gave first importance; providing adequate transport would cost less than engaging extra staff. Even more commonly suggested was the employment of ancillary staff in schools and at clinics, whether nurses, voluntary helpers or clerks, to relieve Health Visitors of less skilled work and to enable them to devote all their time to their proper functions. Among the employments now carried out by Health Visitors that ought to be delegated to others were mentioned receptionist duties, weighing and measuring, food selling, stock checking, laundry checking, clerical duties (filing and re-filing, etc.).

99. Lastly, Health Visitors must be treated as professional workers able to act with a large measure of independence. Within the general policy of the local health authority, they should be responsible for their own allocated area and left much freedom to organise their own work and to harmonise it with that of other workers in the area, untrammelled so far as possible by undue demands from the department for records and statistics. For this they needed certain essentials—a telephone and an office or at the least a regular "port of call" where at stated times they could always be found.

CHAPTER II

SOME LOCAL PROFESSIONAL VIEWS

100. As we indicated in the introductory chapter we visited a number of areas to discuss with people on the spot the way in which Health Visiting services were being given. We visited successively Birmingham, Newcastle, Glasgow, Bristol and Cardiff. While we were at Newcastle, Glasgow and Cardiff we discussed problems of interest at length with officers of neighbouring Counties—Northumberland, Ayrshire and Glamorgan—and we also were able to discuss certain features of the work in Durham and Falkirk.

We did not select the areas as in any sense typical but because in each case there was at least one special feature of interest from the point of view of Health Visiting—for example, the relatively great degree to which Health Visiting and general practice are associated at Birmingham. In fact they could serve as good examples of services in large authorities and the problems we were most concerned with certainly occur in most such areas.

101. Except in the case of Birmingham and Bristol preliminary surveys of Health Visiting were made by independent observers, to help us in our discussions. At each visit we first discussed the survey with the observer and in all cases except Newcastle and Northumberland (for which the reports unavoidably arrived too late) we were able to discuss her comments with the medical officers of health concerned. In addition we had the opportunity to talk to senior medical staff, senior and junior Health Visiting staff, general practitioners, almoners or other social case-workers, and, in most cases, psychiatrists, chest physicians, senior nurses, midwives and others. The main features of interest emerging from these discussions are described below.

102. The field of work covered by Health Visitors varied considerably. In Cardiff, Glamorgan and Northumberland the whole general duties' field was covered; in Ayrshire (where combined work was done) and Bristol, tuberculosis was the only specialised branch of Health Visiting; in Birmingham tuberculosis and school work were separately organised; in Newcastle all except school work was included in the Health Visitors' work and this was in process of integration; while in Glasgow there were separate organisations for maternity and child welfare work, school health and tuberculosis, and the city had an unusual feature, a section of nurses attached to the housing department.

Combined Duties

103. As in the case of the formal evidence we received from organisations, views on combined duties as opposed to full-time Health Visiting depended almost entirely on the experience of the witness. None of the Counties visited in England and Wales—which have fairly extensive rural areas as well as urban areas—had or wanted a combined service. Ayrshire wanted nothing else, whether in town or countryside. The County Boroughs and Glasgow saw no advantage in combination; on the other hand Falkirk, a sizeable town, claimed to have run a successful service for many years on this basis. Health Visitors' views, often very firmly expressed, generally coincided with the views of their employing authorities. It was not apparent that closer relationships existed between combined workers and general practitioners than between the latter and full-time Health Visitors where good contact had been established. Some of the general practitioners we saw were clearly attracted to the idea of combined work; some opposed it. Otherwise we received no new evidence for or against the majority view of Health Visitors and their employers that combined work was not to be recommended.

School Health Service

104. Varying views were expressed about the organisation of the School Health Service. In Birmingham, for example, though "family visiting" was thought to be an ideal principle, some thought it could in practice complicate

intolerably the work of the Health Visitor. She would have to deal not only with school and home but also with hospitals and perhaps several general practitioners—for the "family doctor" by no means always served all members of one family. Great difficulty would be experienced in matching Health Visitors' areas to the catchment area of one or more schools. In Glasgow, on the other hand, a separate service was justified on the ground that the volume of work of the school nurse was great and her contacts were almost invariably within the education system. Home visits need not be frequent, for parent-attendance at examinations was excellent. Thus there was no point in bringing in the local health authority's Health Visitor. In other areas no administrative difficulty in integration was seen, though the view was expressed by a Health Visitor and a general practitioner in Ayrshire that school work added unduly to the burden of routine work. We noted with approval an arrangement in Northumberland by which talks by a Health Visitor on mothercraft were included in the school curriculum and many girls took the certificate of the National Association for Maternal and Child Welfare.

Tuberculosis Services

105. There were widely varying views on the organisation of the tuberculosis service also. The most complete separation from the main body of Health Visitors seemed to exist in Birmingham, where tuberculosis visitors were not the responsibility of the Superintendent Health Visitor. Elsewhere the main points of contention were the desirability or otherwise of specialisation on tuberculosis, the nature of the Health Visitor's work at clinics and the training needed for the work.

106. Most chest physicians were in favour of specialisation. We were frequently told that tuberculosis must still be regarded as a medical and social problem of special urgency. There was no shortage of beds for ordinary cases but the organisation of home treatment, tracing of contacts and development of prophylactic inoculations had increased and in future would increase the volume of work. Close contact between chest physician and home visitor was needed and would be difficult to organise if clinics were few and scattered (or, paradoxically, if they were many and ever-open), unless a full-time worker was employed. General duties staff tended to lack knowledge of and interest in the work though this might be improved by refresher training. Above all they lacked time—especially combined duties staff.

107. At the clinics, duties varied fairly widely. The general impression was that Health Visitors commonly played a large part in running the clinic (except that they did no treatments and nothing in the way of almoning work). Their duties might include chaperonage, reception, weighing and recording as well as reporting on home conditions and receiving instructions from the doctor. In one case it was proposed to relieve them of duties of an unskilled kind but it was feared that "dilution" would be resented! Full-time visitors seem normally to have seen new patients as they were diagnosed but rarely attended with patients from their own areas thereafter.

108. A rather different impression was given in North East England. Here general duties staff were preferred because they had better knowledge of families and conditions in their smaller areas. New patients were not seen by the Health Visitor at clinics but were notified to her, whereupon she at

once visited the patient at home and reported to the chest physician. Subsequently appointments for patients were adjusted so that their own Health Visitor could attend at the same time. This was sometimes difficult but if attendance was missed the gap could be filled successfully by consulting clinic records and discussing the situation with the chest physician at a case conference or other convenient opportunity. In these areas, the Health Visitor's work was restricted to health education and social work; the running of the clinics and the giving of treatments were a hospital responsibility.

109. The respective roles of Health Visitor and almoner at clinics were also various. Generally the view was that almoning was a necessary feature of clinic work. Almoners were particularly useful in dealing with difficulties that stood in the way of early admission or continued treatment, with resettlement problems and with other more complex problems for which the Health Visitor lacked time or expertise. They supplied an element of continuity at clinics without full-time visiting staff. On the other hand, some Scottish opinion held that the social worker was needed only because of the time factor; full-time Health Visitors could do the job just as well. No need for an almoner was felt at Bristol, too, but a "welfare staff" was available for social problems.

110. There was no unanimous view on the training needed for the work. Some chest physicians thought special knowledge of and interest in tuberculosis most desirable but the British Tuberculosis Association's certificate was thought to be more relevant to bed-side nursing. The Health Visitors' certificate was thought to be essential by most but quite unnecessary by a few.

111. It was apparent that those responsible for the service found themselves in a dilemma. Chest physicians, by and large, wanted full-time staff to do their work in their way, although some recognised that specialised staff might tend to become narrow in outlook and isolated from the main body of Health Visiting. On the other hand they also wanted fully qualified staffs. It seemed to many unlikely that they could have both their wishes fulfilled, for qualified staff were unlikely generally to see sufficient professional satisfaction in, and be attracted to, full-time specialisation in tuberculosis alone. Some local health authorities have felt that, while tuberculosis remained a problem of immediate urgency in their areas, specialisation was justified. The tendency therefore was to accept staff with less than the desired qualifications in order to have full-time staff.

Specialisation

112. We had many opportunities to discuss specialisation in other respects, usually in connection with hospitals. In Glasgow the main branches of Health Visiting were all specialised. This was justified on the grounds that public health problems in that city were still of such a magnitude that special measures were necessary to deal with them. An experiment in general duties work in one area had failed partly, it was true, because the areas worked were too small, but partly also because staff tended to pursue their own interests, to the detriment in particular of tuberculosis. Further experiments in the direction of decentralisation and generalisation were, however, contemplated.

113. There was little or no fractional specialisation in the areas visited except in Birmingham, Bristol and Cardiff. In Birmingham, the indication for such specialisation was said to be the need for co-ordination in a subject of special importance, for example, the care of the aged and the care of the unmarried mother. A similar view would be held in Bristol. In Cardiff specialisation was practically confined to hospital after-care. Here the favourable conditions were thought to be the availability of suitable staff, a definable problem and a hospital department of limited size whose medical staff were keen to co-operate. Special follow-up of gastric disorders, for example, might thus have to be reconsidered because demands from hospitals were likely to exceed the possibility of specialist staffing. In all these areas specialists were expected to link up with district colleagues. Some importance was attached to specialisation as a means of furthering staff education. Except for the psychiatric and diabetes specialties (which called for special training) special posts rotated about every two years among volunteers for the work. All specialists helped their colleagues with problems on which they had become expert. While the value of certain specialties was confirmed in Cardiff, it was agreed that they were in a sense a luxury : they did nothing to relieve the burden on general duties staff.

114. An account of the way of working of some of the specialists whose work we discussed may be illuminating. In Birmingham, one visitor was attached to a general hospital where there were four medical wards for children. She attended for two sessions a week at the hospital for discussion of cases with the paediatrician, ward sister and almoner. She would spend another two sessions visiting homes, assessing the possibilities for discharge home or to a convalescent home. Special attenion was naturally paid to problem families, which would be discussed with the district staff. (The rest of her time was spent on the care of the aged and chronic sick.)

A second Health Visitor worked with the Children's Hospital. She did ward rounds with the almoner twice weekly and paid visits accordingly, reporting to the almoner. She helped to supervise home treatment of discharged children. She had a small area in which she did selective visiting on a general duties basis. Generally these arrangements seemed satisfactory to the hospital staffs and Health Visitors alike. Home visits by the almoner were not eliminated, especially where children were re-admitted, and administrative work, for example arranging convalescence, was held to be the almoner's job.

115. Four different specialties were discussed in Bristol. A "problem families" specialist was concerned with some 60 families—10 in conjunction with family service units, 30 with other agencies and 20 on her own account. The size of her contribution depended on the importance of the health aspect. She thought her present case-load was as much as she could deal with. A second Health Visitor specialised in blind welfare, but primarily the hospital treatment aspects—following up clinic attenders, encouraging them to take or continue treatment and explaining it. She was concerned with adults, mostly the aged, and had little to do with children. A third Health Visitor besides looking after a small district dealt with premature babies. If they were born in hospital she undertook intensive visiting on discharge ; if born at home, they were in the care of a specialist midwife until they weighed six pounds ; in either case, she handed over to the district

Health Visitor usually at about three months (after examination at a follow-up clinic). The fourth specialty dealt with the aged. There were 3,600 cases on the register. The Health Visitor undertook, in co-operation with other agencies, to provide "any sort of help" that was needed. She seemed most concerned with the aged sick. One of her most important jobs was assessing special priorities for admission to hospital; her reports were generally accepted without question.

116. In Cardiff, two Health Visitors were attached to the paediatric department of the teaching hospital, retaining their connection with ordinary duties by keeping a small general district. Their principal work was visiting out-patients at home, before admission and before and after discharge where necessary, reporting on home conditions and interviewing parents at home or at clinics. They attended ward rounds, case discussions and seminars and gave lectures on their work to medical students. In Glamorgan, specialisation in this work was not practicable. The paediatrician got over the difficulty by devising a standard report pro forma which the Health Visitor completed and discussed with the divisional supervisor.

117. We were especially interested in the psychiatric specialist. This Health Visitor was chosen from a short list of volunteers all of whom were prima facie suitable. It happened that she had mental nursing qualifications. She was given one year's special in-service course, however, before being fully employed. She worked with two social workers taking about the same case-load. She attended all out-patient sessions and did the first follow-up home visit for her cases and checked defaulters. She visited hospital patients before discharge and helped in re-adjustment afterwards. She acted as liaison officer between hospital and local health authority in any matter of after-care and advised her general duties colleagues on problems within her field; one of her incidental functions was informal staff education. It is noteworthy that the cases allocated to her and to the social workers differed in kind; the latter were concerned with cases in which psychiatric factors predominated, while the Health Visitor dealt mainly with socio-economic factors. The medical superintendent of the mental hospital expressed his warm appreciation of the possibilities of further development on these lines.

We were told that some use was made of general duties Health Visitors in the child guidance service in Cardiff. Results were poor at first but improved.

118. It is convenient to record here that a mental hospital near Newcastle has experimented with some success in the employment of Health Visitors in psychiatric work. Selected cases were allocated to visitors under the supervision of medical staff and a psychiatric social worker. Some thirty cases had been handled in this way and in at least six cases the need for admission had been avoided or delayed. They were mostly chronic cases or old people with mild symptoms and the work involved explanation and re-assurance to families, practical help to meet nursing needs, friendly support for the anxious patient, and periodic checks on preventive treatments (for example, in epileptic cases). The danger of duplication had been avoided by consultation and joint visits.

Health Visitors and General Practice

119. We were naturally concerned with the relations between general practitioners and the Health Visiting Service. Before our visits all areas had had a chance to discuss the circular issued by the British Medical Association and Society of Medical Officers of Health urging co-operation. We found that its principles were fully accepted by both practitioners and authorities but practical progress was uneven. Our visits enabled us to hear and sympathise with the difficulties of both sides and learn some of the methods of approach adopted to bring about co-operation.

120. In Birmingham development had started earlier and had been more rapid than elsewhere. Health Visitors and general practitioners had been introduced to each other at a series of meetings at clinics. Afterwards Health Visitors had called on the doctors and had almost invariably been well received. Nearly 15 per cent. of doctors were holding clinic sessions for expectant and nursing mothers (and some for older children) which the Health Visitor attended for health education purposes. Maternity and child welfare work was the basis of the working relationship, one of the most important subjects being infant feeding. The link with doctors in the care of mothers and children was clearly important as, since 1948, mothers were much more inclined to consult a family doctor. Many doctors, however, found a variety of useful tasks for Health Visitors among their other patients, mainly the aged. Besides attending fixed surgery periods when most of the patients were women and children, a Health Visitor occasionally accompanied a doctor on his rounds. The difficulty of overlapping practices and areas had been got over, largely, by careful liaison. Each doctor knew the Health Visitor working in the area of his own surgery. If she did not cover the whole practice, she would, if necessary, pass on his instructions to a colleague in the area concerned. This worked well. One Health Visitor worked with six doctors in her area without difficulty. We understand that this ratio of Health Visiting Staff to doctors was thought to be about right. One of the doctors whom we met thought there was sufficient work for a full-time worker in a practice of three doctors (but some of the work suggested would be more appropriate to a home nurse and a secretary).

A greater difficulty was the heavy demand on staff time. It was in any case the policy of the authority to encourage selective visiting, that is, after "first visits" the Health Visitor had full discretion. This policy was a necessity while co-operation with doctors was developing; over-use or misuse of staff time would gradually decrease, it was thought, and doctor and Health Visitor would complement each other. Appreciation of the service, and especially of clinic facilities, was expressed by the doctors we saw.

121. In Bristol, nearly one-third of the doctors on the obstetric list saw their own maternity cases in the authority's clinics. Here there was a close tie-up with the hospital service and hospital booked mothers attended these clinics. There was, as in Birmingham also, a single set of records available to hospitals, practitioners and the local health authority. The doctor thus knew of virtually all pregnancies in his practice and had all relevant information easily to hand. Midwives' and Health Visitors' sessions—and if possible the consultant-obstetrician's session—coincided with the doctor's visits. Other staff came in for consultation when they knew the doctor was there. Clinic nurses were available for routine duties. The only

disadvantages were that a few patients objected to the clinics and the opportunity for consultation on general matters was lacking.

122. We visited the William Budd Health Centre in Bristol and heard from doctors there how valuable this service was to them. Owing to the co-operation of the Health Visitor, one doctor said, for example, that he was in closer touch with families from birth to school days. Dealing with children in his practice was far easier with the help of the Health Visitor. Health Visitors known to be attached to a doctor had an easier entrée to the family. In return they helped to reduce the burden on the doctor by relieving him of repeated consultations, for example, with patients whose main need was sympathetic reassurance, and by taking up social aspects of illness situations, such as helping to secure re-housing. The organisation of group discussions among mothers was a great help—examples were quoted of the effectiveness with which mothers who had benefited by health education could act as missionaries among their neighbours at such sessions. The health centre served an estate in which many social difficulties still were apparent. Partly at least through the activities of the Health Visitors the centre had become the meeting point of a dozen social agencies concerned with such problems.

At both the health centre and the clinic that we visited it was clear that success largely turned on the personality and ability of the Health Visitor in charge.

123. We had the opportunity at Bristol to discuss co-operation with other doctors who were frankly critical. They claimed that they rarely heard of Health Visitors except where they gave conflicting advice—a general complaint among doctors not in touch with Health Visitors which we did not hear where contact was well established. They were irritated by and disapproved of the activities of the specialist on the aged sick. They had some need of help with their practices—mainly with the aged and with growing children (with whom preferably the home nurse should deal) and with infants up to six months (with whom the midwife should be trained to cope). Home nurses were overworked and every effort should be made to recruit more. The doctors saw no need of a third profession linked with nursing but undertaking also social work; social work was a task for fully trained social workers. These doctors took the view that the Health Visitor's training and experience consisted largely of nursing sick adults in hospital yet their work was mainly with normal and healthy mothers and children in their homes. Though Health Visitors were concerned with advising on maternal and child welfare, only a small part of their training was devoted to this; yet this small part was taken in a course already too short to fit the Health Visitor for medico-social work. Superficially these arguments have much force; but it seems probable to us that the additional work expected of nurses and midwives would entail additional training not unlike that of the existing Health Visitor.

124. It would be a fair general conclusion that in the areas visited there had been apathy rather than antipathy on the part of many doctors. While the will to co-operate was general, there was sometimes no clear conception of the objective, sometimes lingering suspicions of motives. It appeared in some cases that each side awaited a move from the other. Initiative from one side only was often not enough. There seemed to be no single measure

certain to produce results. It would be natural, for example, to assume that combined workers would achieve a better relationship with doctors, because they were home nurses and midwives, than would full-time Health Visiting staff. There seemed, however, to be no difference between the relationships of doctors with combined workers in Ayrshire and with general duties workers in Northumberland, as described to us. It would be natural to start by associating Health Visitors and doctors in maternity and child welfare work. This achieved much success in Birmingham, where the authority accepted fully the consequent drain on Health Visiting time, but less success in Bristol, where equally generous clinic facilities were offered. In Newcastle, on the other hand, most of the ante-natal work was done by general practitioners but there had been little subsequent contact with Health Visitors. In Newcastle, general practitioners were aware that Health Visitors were working intensively on the child morbidity inquiry among one thousand families initiated by the late Sir James Spence,(1) but little advance in co-operation resulted. One procedure was initiated in Newcastle shortly before our visit that may have good results. Each Health Visitor after a first visit to an infant notified the family doctor of the fact and gave her name and means of getting in touch with her. Other interesting suggestions included discussions between local B.M.A. branches and Health Visitors themselves and the introduction of Health Visitors to medical liaison meetings. We were convinced that co-operation was always practical but the means of achieving it would depend on local initiative and imagination.

The Health Visitor in a Social Work Role

125. While generally witnesses were very willing to pay tribute to the good work of Health Visitors there was criticism of some aspects of their work. In almost every area we visited we met almoners employed by either the local health authority or the hospitals. In Bristol we had a brief talk with representatives of the Council of Social Service and in South Wales with children's officers. All—especially the almoners—welcomed co-operation with the Health Visitor and, if anything, wanted closer direct contact with field visitors. They saw no ethical barrier to free discussion of cases of common interest. With varying degrees of emphasis and varying illustrations, however, they referred to shortcomings that they said were apparent in the Health Visitor's activities purely as a social worker, so far as these went beyond the matters with which she inevitably had to deal to make her everyday visiting effective. These witnesses were not of course any more representative than others whom we saw and they disagreed at some points with the official evidence given by bodies of which many were members. On the whole, however, the viewpoint was uniform. The general criticism amounted to the opinion—backed by experience—that *in general* Health Visitors (for whatever reason) did not deal adequately with situations that called for more than a superficial appraisal or for psychological insight. In such cases they were inclined to be overconcerned with their own purposes and to attribute too much importance to environmental factors which might in fact not be the crucial ones. Those who had a better insight ran the risk of going too far, handing over either not at all, or too late. Reports by Health Visitors were

(1) Spence, J. *et al* (1954) " A Thousand Families in Newcastle-upon-Tyne: an approach to the Study of Health and Illness in Children ". Oxford University Press.

misleading sometimes for these reasons. The inadequacy of reporting on difficult cases was mentioned also by some medical witnesses. While reports were usually sufficient for their purposes, they were inclined to call for a report from a more highly trained social worker in more complex cases and not to rely solely on the background given by the Health Visitor. Various reasons were advanced—lack of insight, lack of knowledge of the task and objects of other workers or lack of training in observation and reporting. Medical officers of health and senior Health Visitors were unanimous that knowledge and ability were not lacking though many agreed that, except in discussion, many Health Visitors were poor hands at passing on what they knew.

Training of Health Visitors

126. Most witnesses, expressly or tacitly, accepted that the Health Visitor should be a registered general nurse in order to carry out her health education work. Some may have had reservations on that point but they would all, we think, agree that a "health" training should form the major part of the course. General practitioners who expressed views on the point felt that the training must commend itself to doctors, especially if the Health Visitor was to be concerned with the sick; a nurse training would satisfy their requirements. If any modification was thought necessary, it was generally on the lines of a nurse training based on the recommendations of the Nurses' Working Party in 1947. There was some support for an integrated nurse/Health Visitor training which would lay stress on public health work from the beginning; two senior Health Visitors thought that it was often difficult to inculcate preventive attitudes in former nurses. There was some criticism of the required midwifery training on the grounds that, being institutional in character, it did not prepare the Health Visitor for domiciliary work. Elements in whatever nursing and midwifery training were needed should not be repeated in the ensuing professional course.

127. Health Visitors while naturally proud of their status as nurses were also concerned about their position relative to other social workers and this partly accounted for anxiety to improve the training in the direction of social work. There was little or no demand for social science courses as such but some thought that courses should be biased towards the social science point of view; the help of University departments to improve the training was thought by many to be essential. (In fact in all the areas visited there was a close link between the training course and the University.) It was generally considered that greater attention should be paid to teaching Health Visitors to write reports that would meet the needs of other workers. The most frequent suggestion by far was that the course should be much more helpful as to the psychological elements in the work of Health Visitors. This was what older Health Visitors thought had been lacking in their training; they had been left to pick up by experience knowledge that could well have been imparted in training. On the other hand some Scottish evidence stressed that experience, personality and a sense of vocation were as important as good training. Only one witness suggested that the course should be shorter than six months—its length was a deterrent—but most thought it should be longer and should contain more practical experience. Some senior staff urged that newly trained staff should have a further period under supervision before taking on full responsibility. Not all suggestions were for new material:

a popular proposal was that health education technique should have more attention. Refresher courses for existing staff were thought to be inadequate at present.

Conditions of Service

128. Though relative salaries were in most witnesses' minds, improvement in the conditions of service of Health Visitors in a broad sense were more commonly suggested. One medical officer of health thought this the most important factor. Two others thought the happy state of recruitment in their areas was due to efforts to make the work as full and satisfying as possible and to provide the "tools for the job" among which they—and others—gave perhaps highest priority to proper transport facilities. The importance to the Health Visitor of having a recognised area of operation and not being shifted from it and the value of a clinic as a base were stressed by many. The hurried way in which work often had to be done was deplored; better quality work and more freedom for initiative gave greater satisfaction to the worker and the better use of clinics would help. A most important deterrent was uncertainty about the field of work that Health Visitors were expected to occupy and therefore about relations with other workers.

It would be a fair summary of our impressions of these visits to say that while progress had been made in the implementation of the policy outlined in Section 24 of the National Health Service Acts, it was uneven. There was still much uncertainty as to the direction and method of change among both Health Visitors and their employers.

Part II. Factual Evidence

CHAPTER III

GOVERNMENT DEPARTMENT STATISTICS AND THE REPORT OF A SURVEY BY THE NUFFIELD PROVINCIAL HOSPITALS TRUST

129. The statistical information that we had at the outset about the numbers and employment of Health Visitors consisted of information from Government departments based on the annual returns collected from local health and education authorities in England, Wales and Scotland. These figures are reproduced in Appendix II. Unfortunately in a number of respects these figures are not comparable as between Scotland and England and Wales or, in England and Wales, as between the Ministry of Health and the Ministry of Education. Some figures may overlap to an unknown extent; in Scotland the figures of health and education staff cannot be separated. Figures for Great Britain cannot, therefore, be given in some instances.

130. The general picture is, however, fairly clear. In Great Britain the number of live births—which has been an important index of Health Visitors' work load—was about 687 thousand in 1935, rose to nearly 1 million in 1947, fell to 764 thousand in 1952 and since then has been falling. The number of children under five years rose from 3·2 millions in 1935 to 3·97 millions in 1947, declined slightly to 3·96 millions in 1952 and fell again to 3·76 millions in 1954. The reverse trend has occurred in the case of school-children aged between 5 and 15 years of whom there were 6·5 millions in 1935, 6·1 millions in 1947, 7·1 millions in 1952 and 7·4 millions in 1954.

England and Wales

131. Appendix II shows that the total number of staff employed on Health Visiting by public health departments and by voluntary organisations rose from 5,684 in 1935 to 6,244 in 1952—an increase of 560. About one-third of the increase occurred after 1947. In 1953, the form of the Ministry of Health's staff statistics was altered to show separately all staff employed wholly on tuberculosis work. Some of these may previously have been counted as doing general duties Health Visiting work. The figures for 1954, therefore, are not precisely comparable. They appear to show a slight decrease to a total of 6,140 general duties staff. In fact, however, the slow upward trend has probably continued. (The number of tuberculosis staff recorded was 569, making a total strength of 6,709.)

The figures of the whole-time staff equivalent of whole- and part-time staff show a parallel increase but at a greater rate. Between 1935 and 1952 the figure rose from 2,692 by 1,430 to 4,122. More than half this increase occurred between 1947 and 1952; this is almost certainly due to the introduction after 1947 of a full-time Health Visiting service in many areas where

combined work was formerly the rule. As in the case of actual numbers of general duties staff, the figure of whole-time staff equivalent showed a slight decrease from 4,122 to 3,885 in 1954. If the equivalent time of tuberculosis visitors were added (507) the total would be 4,392.

132. The number of visits paid by Health Visitors has risen continually since 1935. In that year 8·2 million visits were paid ; in 1947 the figure was 8·4 million. Since then, however, the rate has risen steeply to 11·5 million visits in 1952. In 1954 the number of visits by general duties staff was 11·6 million, but the figures, like staff figures, are affected by the change in the form of the statistics. If the number of visits by tuberculosis staffs (646 thousand) is added, the total number of visits becomes 12·2 million. The true figure for comparison between 1954 and earlier years lies therefore between 11·6 and 12·2 million ; it is apparent that the rising trend continued. If the whole-time staff equivalent figures are applied to the number of visits it will be seen that there has been a slight increase in the intensity of visiting between 1947 and 1952, when the figure was about 2,800 visits(1) per unit of staff. In 1954, the figure for general duties staff had risen to 3,000, while the figure for tuberculosis staffs was only about 1,400. These changes are not easy to account for. The number of live births has slowly fallen since 1947, the number of children under five years has fallen since 1949. The number of school-children is not a relevant index since they are little visited in the country as a whole.

133. Before 1948, visits to mothers and children alone were counted. After 1948, other cases visited by Health Visitors were counted for the first time. Some of the increase in the number of visits shown in Appendix II between 1947 and 1949 must therefore be artificial. In the first full year of the National Health Service, 1949, the proportion of visits to mothers and children was 90 per cent. Up to 1952 it did not drop below 87 per cent. One object of the 1953 revision of the annual returns was to obtain a more detailed classification of visits to discover whether the figures of visits to mothers and children concealed a wider range of work. As Appendix II shows, however, the figures for 1954 on the new basis showed little or no change in the distribution of the visits of general duties staff. If the visits of tuberculosis staff are added the proportion of visits to mothers and children in all visits drops to 82·7 per cent. Of the " other visits " paid by general duties staff 250 thousand were recorded as paid to tuberculosis cases. The largest number of the remainder, it is thought, was paid to the aged.

134. Government statistics thus suggest that the general pattern of Health Visiting has not changed since 1948, except that more Health Visitors in the public health service are giving some of their time to the work of the School Health Service—a matter of work in the school and clinic rather than in the homes. It may also be concluded that slightly more visits are now being paid on average to each client (for any purpose) than was the case in 1949. It certainly seems that, as witnesses have told us, demand for service is out-running the supply of staff.

These figures, of course, cannot indicate changes of quality. It is apparent that visiting in the ante-natal period is becoming a slightly less important factor in Health Visiting and the care of the aged is becoming, some think,

(1) This figure represents a *rate* of visiting not an average of actual visits carried out; it is not, therefore, comparable with the standard of visiting suggested in Chapter XIV.

slightly more important. There may, however, have been other changes that do not appear on the surface—in a closer association with hospitals and general practitioners or in the concentration of visiting on more difficult cases. We consider in Chapter V how far " visits to mothers and children " may conceal work not only concerned with purely physical questions but also dealing with matters of a psychological and socio-economic character.

135. The 1953 revision of the form of statistics asked for the first time for the number of families and households visited by Health Visitors (except those specialising in tuberculosis). The term " family or household " was not defined in the return and there may have been some duplication due to migration or some under-statement, since families visited by tuberculosis specialist visitors are not included. The figures are not, therefore, too precise but provide an opportunity for estimating the proportion of families covered by Health Visiting. The 1954 figures indicate that the total number of families or households visited by Health Visitors was about 3·25 million. It is interesting to compare this with the results of the 1 per cent. sample of the population of England and Wales taken at the census of Great Britain, 1951, which show that the total number of private households (not, however, counted in a manner directly comparable with the Ministry's figures) was then about 13 million.

Health Visitors thus covered in some way only one-quarter of all families and households. Since the great bulk of their visits was for maternity and child welfare purposes, they could hardly be concerned at all with the 7·4 million households and families, in which the sample showed there were no children under 16 years of age. At present, the Department's returns show that all or almost all children under five years are visited at least once but, on average, not more than two or three times annually. If Health Visitors are to be concerned in future to a greater extent with the problems of adults and adolescents generally or of homes where there are older children it is clear that either there must be many more Health Visitors or child visiting will be reduced, even if measures are taken to shed unnecessary duties and improve facilities for visiting. If the change in emphasis is very marked, it might mean that some children who ought to be visited could not be visited at all.

136. In the School Health Service in England and Wales there was little absolute change in the staffing figures between 1935 and 1952—the number of school nurses was 5,644 in 1935, 5,278 in 1947, 5,690 in 1952, but the number rose to 6,157 in 1954. There has been, however, little change corresponding to the recent increase in the number of school nurses, in the equivalent whole-time staff employed in the work ; the figure was 2,506 in 1947, 2,519 in 1952 and 2,565 in 1954. This may result from an increasing tendency for Health Visitors employed by local health authorities to be employed also as school nurses, a trend which has been fairly marked in the last three or four years.

Scotland

137. In Scotland the staffing picture shows a relatively larger increase in the absolute numbers of staff. Although the picture is obscured because separate figures for the Health Visiting and school nursing services are not available it seems probable that demand here also has exceeded supply.

Despite the increase in staff the ratio of staff to total visits suggests that the number of visits paid by each Health Visitor rose by about one-third between 1935 and the early years of the Health Service, though there has recently been some levelling-off.

Nuffield Provincial Hospitals Trust Survey

138. In 1950 the Nuffield Provincial Hospitals Trust engaged in an analysis of the work of public health nurses including Health Visitors and school nurses and we were able to see their report which was privately circulated. We summarise the main points of interest in this Chapter as a matter of convenience. We refer to some of them again in connection with our own survey of Health Visitors' work in Chapter V.

139. In the course of the survey records were obtained from a random sample, in almost all local health authority areas, of about one-seventh of all public health nurses (excluding those midwives who did not also do home nursing or health visiting). Records were taken in two separate weeks at times of the year when activities might be regarded as normal but they did not take account of such variations as would occur if work was organised on a monthly basis, that is, there might be marked differences between the survey weeks and succeeding weeks.

140. About half the staff surveyed were Health Visitors, tuberculosis visitors, school nurses or combined workers. Almost all those who did maternity and child welfare work or school nursing or some combination of those, with or without tuberculosis, worked in urban areas or "mixed" (urban-rural) areas. Almost all combined workers were in rural areas. Nearly all the staff who did maternity and child welfare alone or in conjunction with school nursing and/or tuberculosis were qualified Health Visitors (and accordingly registered nurses). About 20 per cent. of the whole-time school nurses sampled held the Health Visitors' Certificate[1]. In England and Wales, 18 per cent. of combined workers had this qualification; in Scotland, the figure was 11 per cent. Almost all combined workers in Scotland were registered nurses, while in England and Wales only two-thirds were so qualified.

141. *The Working Week.* Generally it appears that the staff surveyed worked about an average of 40 hours per week, possibly with a fairly wide spread over of hours. Those who did only school nursing did very little visiting. The combined workers on the other hand did over 30 hours visiting and very little clinic work. The remainder—the general duties staff—did about 18 hours visiting and 15 in clinics. They did about 7–9 hours clerical work in addition to time spent on clinics and visiting, while the school nurses and combined workers averaged 4–5 hours. The case-loads of various staff groups were analysed; full-time Health Visitors had very heavy case-loads not apparently much reduced if additional duties were undertaken; combined workers had light Health Visiting case-loads.

142. *Home Visiting.* The records surveyed showed that most visits to children aged 0–5 were done by Health Visitors full-time on maternity and child welfare or doing school nursing and tuberculosis in addition; these

(1) Most school nurses are, of course, employed part time in this service; taking whole- and part-time staff together, about 80 per cent. have the Health Visitors' Certificate at present.

visits accounted for 70 per cent. to 75 per cent. of all visits by these staff. Most of such visiting of school children as was necessary was carried out by full-time school nurses who carried out about 60 per cent. of all visits to that group. In the case of combined workers the proportion of child visiting was lower—26 per cent. of all visits—the balance being for midwifery or nursing purposes.

No significant degree of specialisation was apparent among Health Visitors themselves. Generally the character of visits showed no marked change from 1948 according to the report; otherwise there is no comment on the subject-matter of visits. Visiting of the aged was virtually confined to combined workers; there would naturally be a demand for nursing work from this group of clients.

143. *Transport.* The survey did not show any serious travel problem. There was apparently a close relation between the type of transport used and the need for it. For the most part the professional Health Visitor had no car while the combined workers were better provided—most staff in rural areas had the use of a car.

144. *Clinic Work.* While nearly three-quarters of Health Visitors full-time on maternity and child welfare work attended ante- and post-natal clinics, less than half of other Health Visitors were concerned with this work. On the other hand all Health Visitors attended child welfare clinics which clearly formed the most important part of their clinic work. Whole-time school nurses attended a wider variety of clinics, apparently more concerned with treatment than examination or education. The amount of clinic work outside the immediate maternity and child welfare or school health field was not significant.

145. The survey examined the volume of work done at clinics and came to the conclusion that they were at that time uneconomic in terms of the ratio of clients to nurses and Health Visitors. It was noted particularly that there were few references to the employment of "clinic nurses" to relieve Health Visitors, that although clerks or voluntary helpers were present at many clinics they had no clearly specified duties and did not relieve the Health Visitor of at least 30 to 40 per cent. of filing duties; they did, however, undertake the sale of welfare foods. Health Visitors spent about half an hour preparing and another half an hour clearing clinics, work which might well have been done by auxiliary staff. Doctors attended most of the clinic sessions recorded and in about a third of the cases the Health Visitor was in attendance upon him.

146. The report made a number of observations on the results of the survey particularly commenting on the need for re-organising clinics so as to avoid preparation and clearing work and clerical and miscellaneous managerial duties, and the allocation to less qualified staff of duties, such as the treatment of minor ailments, that did not call for the Health Visitor's qualifications. Special anxiety was expressed about the concentration of unqualified staff on visiting work in rural areas. It was suggested that over-lapping of services in urban areas could be avoided by employing Health Visitors on a broader range of duties. This would help to align the objectives of the Health Visitor more nearly with those of the general practitioner but the opinion was expressed that generalisation of duties should not involve undertaking home nursing or midwifery.

CHAPTER IV

THE WORKING PARTY'S STATISTICAL INQUIRY OF LOCAL AUTHORITIES

147. We thought it necessary to supplement the information given in the previous chapter by collecting information about the present numbers of qualified and unqualified staff engaged in the work, the age distribution of Health Visiting staff, the proportion of staff time absorbed by various parts of the service and the ways in which various duties were grouped. We therefore asked all employing authorities to assist in a statistical inquiry covering England, Wales and Scotland and relating to the position at 31st December, 1953. The figures resulting from this survey are summarised in Appendices III–VI. Since our own survey had different objects and started from a different basis from the surveys described in Chapter III, a direct comparison between them is not possible.

148. For the purposes of our survey we defined a Health Visitor as a person with the Health Visitors' certificate of the Royal Society for the Promotion of Health of England and Wales or of the Royal Sanitary Association of Scotland; or deemed to be a Health Visitor under Regulations made in 1930 (England and Wales only). The term did not include, in England and Wales, persons authorised to act as Health Visitors by dispensation of the Minister or, in England, Wales and Scotland, other persons employed on recognised Health Visiting duties, but not possessing a Health Visitors' certificate. Those who held the certificate or were deemed to be qualified are referred to throughout as "qualified Health Visitors" and are shown as such in the tables, whatever their employment. Staff without qualification are referred to (and counted) as "acting Health Visitors" throughout. On the other hand staff without the qualification who were whole-time tuberculosis visitors or were engaged on school nursing duties not normally carried out by Health Visitors are shown separately under suitable headings. The survey covered administrative as well as field staff and staff employed by voluntary bodies acting for the authorities as well as those directly employed. Very few authorities were unable to provide the information requested of them. As the notes to the Appendices show, the omissions were too small to affect materially the main figures or any conclusions drawn from them.

Number, age and civil status of Health Visitors

149. As the tables show, the total number of qualified and acting Health Visitors and whole-time tuberculosis visitors in the health and education services in Great Britain was 9,508. The following summary table shows the distribution of staff between County and County Borough areas. The figures in brackets are percentages.

It will be seen that more than twice as many Health Visitors were employed in County areas (69 per cent.) as in County Boroughs, Cities and Large Burghs (31 per cent.). The proportion of all staff who were qualified was 71 per cent. but there was a big difference between England and Wales

(74 per cent.) and Scotland (56 per cent.). The lower Scottish figure is almost wholly accounted for by the Counties (37 per cent.)—in the Cities and Large Burghs the figure was 83 per cent.

TABLE 1

Numbers of Health Visiting Staff Employed

Category of Staff	England and Wales		Scotland	
	Counties	County Boroughs	Counties	Cities and Large Burghs(1)
Qualified Health Visitors	4,157 (74)	1,725 (74)	330 (37)	521 (83)
Acting Health Visitors	1,366 (24)	500 (21)	559 (62)	101 (16)
Tuberculosis Visitors	132 (2)	105 (5)	8 (1)	4 (1)
TOTAL	5,655 (100)	2,330 (100)	897 (100)	626 (100)

(1) In Scotland, Counties of Cities and Large Burghs are local health authorities (corresponding to County Boroughs in England and Wales). They are referred to in this Report as Cities and Large Burghs.

150. The number of tuberculosis visitors employed (who do not hold the Health Visitors' certificate) was only 249, by far the majority of these being employed in England and Wales, and slightly more than half in the County areas.

151. The percentage distribution by age-groups of Health Visiting staffs in Great Britain is shown in Table 2 below.

TABLE 2

Percentage of Qualified and Acting Health Visiting Staff in certain Age Ranges

Authority/ Age Range	England and Wales				Scotland			
	Counties		County Boroughs		Counties		Cities and Large Burghs	
	QHV	AHV	QHV	AHV	QHV	AHV	QHV	AHV
Under 30 years	8	6	14	16	6	12	8	15
30 and under 50 years ...	74	51	70	59	70	58	72	62
50 years and over ...	18	43	16	25	24	30	20	23
TOTAL... ...	100	100	100	100	100	100	100	100

QHV = Qualified Health Visitors.
AHV = Acting Health Visitors.

It will be seen that 76–84 per cent. of qualified Health Visitors were under 50 years, and thus, other things being equal, will still be serving in ten years time. By then, however, most of the older staff—perhaps many of the present administrative staff—will have retired or will be on the point of retiring. The age of entry to training being high, it is likely that at least 50 per cent. of qualified staff have trained within the last ten years and probably most of these within the last five years, i.e. since the last major revision of the syllabus.

152. The age-distribution of acting Health Visitors was rather different. Between 57 and 77 per cent. of these staffs in the various authorities were under 50 years of age. On the assumption that it is desirable to replace acting by qualified staff, the situation of the various groups of authorities differs widely. In the English and Welsh Counties about one-quarter of all staff were acting Health Visitors, but 43 per cent. of the latter were over 50 years of age, that is, if no more such staff are taken on the proportion will cease to be significant within 10 years. The position in the Scottish Cities and Large Burghs is similar, but in the English and Welsh County Boroughs it would be rather less favourable. It would be possible for all these authorities, however, to have a fully qualified staff within the period with a relatively minor degree of reorganisation. In the Scottish Counties, on the other hand 62 per cent. of all staff were unqualified and of these 70 per cent. were under 50 years of age. These authorities would need to secure that a large proportion of their existing staff underwent a course of training or that a major reorganisation of the work was undertaken in order to reduce the proportion of unqualified staff even to manageable proportions.

153. There were noteworthy differences in the distribution of Health Visitors by civil status. The following table shows the proportions of each group who were single and married or widowed, respectively.

TABLE 3

Civil Status of Health Visiting Staff

(Percentages)

Category of Staff	England and Wales				Scotland			
	Counties		County Boroughs		Counties		Cities and Large Burghs	
	Single	Married/ Widowed	Single	Married/ Widowed	Single	Married/ Widowed	Single	Married/ Widowed
Qualified Health Visitors	79	21	79	21	90	10	90	10
Acting Health Visitors	57	43	45	55	84	16	67	33

The table shows considerable differences between England and Wales, and Scotland, and between qualified and acting staff. The high proportion of single staff in Scotland suggests that as a matter of policy Scottish authorities are disinclined to engage married staff, or that there is a greater tendency than in England and Wales for married staff to give up the work. The much higher proportion of married acting Health Visitors, particularly

in England and Wales, possibly reflects both a different housing policy towards home nurses and midwives in the county areas and a more settled staff. The figures for staff who were widows were consistently low—ranging from 3 per cent. of qualified Health Visitors to 7–9 per cent. of acting Health Visitors. Either this source of recruitment is not large or there are few attractions in the work for such recruits, who will often be older women. There is little to suggest that a significant reduction of the shortage of staff would be forthcoming from this direction.

Specialisation and Combination of Duties

154. One part of our inquiry dealt with the ways in which Health Visiting duties are made up and how they are combined with other duties. We have already defined specialisation in terms of staff who spend the whole or substantially the whole of their time on one of the main branches of the services or alternatively on some fraction of that branch. Specialisation of the second kind—fractional—was numerically insignificant but covered a wide range of subjects. The returns from local health and education authorities showed only 46 full-time staff and 90 part-time staff in England and Wales and 21 whole-time and 11 part-time staff in Scotland. In England and Wales these visitors were spread over 11 County Councils and 37 County Boroughs and in Scotland over 4 County Councils and 7 Cities and Large Burghs. The following table shows the most common fractional specialties on which staff were engaged.

TABLE 4

Fractional Specialist Duties carried out by Health Visiting Staff

(Whole-time and part-time Staff)

	England and Wales				Scotland			
	Counties		County Boroughs		Counties		Cities and Large Burghs	
	QHV	AHV	QHV	AHV	QHV	AHV	QHV	AHV
After-care ...	14	—	13	—	—	—	2	—
Venereal diseases	2	—	9	2	—	—	7	—
Old people ...	1	—	11	3	—	—	2	—
Infectious diseases	—	—	4	5	—	—	1	—
Home helps ...	4	1	—	—	—	—	2	—
Diabetics ...	1	—	12	—	—	—	—	1
Orthopaedics...	1	—	2	1	—	—	—	—
Premature babies	—	—	2	1	—	—	—	1
Problem families	1	—	2	—	—	—	—	—
Unmarried mothers	1	—	6	—	—	—	—	—
Research ...	2	—	—	—	—	—	1	—
Group teaching	2	—	1	—	3	—	6	—
Other	4	—	16	12	1	1	4	—
TOTAL... ...	33	1	78	24	4	1	25	2

NOTE:—QHV = Qualified Health Visitors.
AHV = Acting Health Visitors.

It seems likely that in a great many cases specialisation occurred because the individual had some special capacity which there was an opportunity to use, possibly in connection with a research project. The group "other" duties on which 38 staff were engaged covered 22 further items (one or two staff per item) including asthma, audiometry, gastric or cardiac disorders, chronic sickness, child guidance, hygiene surveys, follow-up of ophthalmia neonatorum etc.).

155. Specialisation also occurred in each of the three main branches—Health Visiting in the local health services (maternity and child welfare and miscellaneous associated duties), school nursing and tuberculosis. Table 5 below sets out the proportions of staff engaged on specialist duties and on other combinations of home visiting duties (excluding wholly administrative and supervisory staff, but including tuberculosis visitors).

TABLE 5

Home Visiting Duties Allocated to Health Visiting Staff

(Percentages of total staff)

	England and Wales		Scotland	
	Counties	County Boroughs	Counties	Cities and Large Burghs
Health Visiting	5	31	1	38
Tuberculosis visiting	6	7	2	13
School nursing	8	23	5	8
Health Visiting/tuberculosis visiting ...	1	6	5	9
Health Visiting/school nursing	31	18	6	9
Health Visiting/tuberculosis visiting/school nursing	25	15	10	15
Combined duties	24	Nil	71	8
TOTAL	100	100	100	100

156. The table shows wide differences of practice between the various groups of authorities. The nearest approach to a generalisation of duties was made in the Counties. In the English and Welsh Counties, a quarter of the staff did Health Visiting with school nursing and tuberculosis visiting, while nearly another third did Health Visiting and school nursing together. Nearly two-thirds of the staff who did combined work were also employed on school duties, or on school and tuberculosis duties as well as Health Visiting. Similarly in the Scottish Counties about one-third of the combined duties staff did school work and nearly three-fifths did school work with tuberculosis work as well. (Incidentally, combined duties included both home nursing and midwifery, with rare exceptions.)

On the other hand, about three-fifths of the staff in County Boroughs and in the Cities and Large Burghs were engaged wholly in Health Visiting, *or* tuberculosis visiting, *or* school work, mostly in the first named. Less than one-fifth were undertaking Health Visiting and school nursing or these activities with tuberculosis visiting. While it appears to be the policy of the urban authorities to achieve a generalisation of duties, they were evidently far from succeeding. It is difficult to see why it should be so generally harder to do this in compact town areas than in rural areas.

It is interesting to note the activities in which acting Health Visitors played a substantial part. They were evident in school work, tuberculosis work (as whole-time tuberculosis visitors) and any form of combined duties. In the English and Welsh Counties two-thirds, and in the Scottish Counties five-sixths, of the combined staff were unqualified (although most were covering a wide range of visiting duties). Almost all staff doing school work only in the English and Welsh Counties and the majority of such staff in the County Boroughs (who also represented about two-thirds of all acting Health Visitors in the latter areas) were unqualified.

Range of Duties

157. We hoped to analyse still further the duties of Health Visitors and to assess the degree to which they were working with others. As a first stage we asked for a statement showing the total number of Health Visiting staff engaged in specified duties together with the equivalent whole-time spent on the duty. This would show not only what proportion of staff gave some time to each duty but also the proportion of total staff time spent on each. If, for example, 100 Health Visitors were engaged in a certain duty it would be important to know whether all or, say, one-tenth of their time was occupied by it. The table would also show the extent to which staff were working part-time in the sense that some of their time was devoted either to services other than health and education or was part-time only. We were, of course, aware that the records of work which are kept by local health and local education authorities would be designed primarily for the authorities' own information and partly also to enable them to complete the routine departmental returns. A considerable amount of labour would be necessary for them to arrive at precise figures ; we invited them therefore to make suitable approximations after discussion with their staff and to decide where the weight of the work was falling. The results obtained were unfortunately not entirely satisfactory. It was not possible, for example, to obtain complete consistency between this table and others. The complications, even of estimating, were no doubt exceedingly difficult especially for the small authorities and those where combined work was prevalent and conclusions drawn from these figures must necessarily be in general terms.

The second stage of this part of our survey was even less satisfactory. We had hoped to discover—especially in relation to duties other than maternity and child welfare, school health and tuberculosis—to what extent other workers were employed in the same fields as Health Visitors. The information given, however, was evidently incomplete. The " other visiting duties " of Health Visitors, shown on the forms returned were too slight to justify reproduction. The summary of this part of the inquiry, which is shown at Appendix V is therefore a much abbreviated form of what authorities were asked to complete.

158. The difference between the number of actual Health Visiting staff, and their whole-time staff equivalent in all areas of Great Britain was so slight that we may conclude that part-time employment is virtually non-existent.

159. As will be seen from the tables in the Appendix, the analysis dealt with both visiting and clinic duties. Authorities were asked to estimate the approximate proportion of time spent by Health Visitors as between these

two classes of work. Not all replied ; the task, again, would be to some extent complicated by the need to take into account duties other than " health " and " education ". An analysis of the replies received (not shown in the Appendix) suggests that in England and Wales qualified Health Visitors spent approximately 54 per cent. of their time on visiting as opposed to clinic work, while in Scotland, 67 per cent. of the time of qualified staff was given to home visiting duties. The figures for acting Health Visitors were very different. In England and Wales they spent 70 per cent. of their time on home visiting duties in the Counties and 23 per cent. in the County Boroughs. In Scotland, they spent 79 per cent. of their time in the Counties, and 61 per cent. of their time in Cities and Large Burghs on home visiting duties. In England and Wales, the high figure in the Counties for acting Health Visitors follows from the home nursing and midwifery duties of these staff—a very much smaller proportion of the work of qualified Health Visitors in the Counties, and non-existent in the County Boroughs. The difference between England and Wales and Scotland is similarly accounted for, in part at least, by the greater volume of home nursing and midwifery work carried out by Health Visitors in Scotland. The low percentage of time spent on home visiting duties in the English and Welsh County Boroughs by acting Health Visitors reflects the high proportion of such staff who were engaged solely on school nursing duties.

160. The following two tables are intended to give an overall picture of the distribution of staff and staff time on the broad classes of duty carried

TABLE 6

Percentage of Health Visiting Staff Engaged on Certain Duties

Category of Staff/ Authority	Total Number of Staff	Administrative and Supervisory Duties	Ante-Natal	Other Maternity and Child Welfare	Schools	Tuberculosis	Home Nursing and Midwifery
All Health Visitors							
England and Wales							
1. Counties	5,457	5	71	85	81	37	23
2. County Boroughs ...	2,221	6	50	67	56	23	n
Scotland							
1. Counties	865	5	68	86	82	64	66
2. Cities and Large Burghs	597	5	52	62	40	31	5
Great Britain	9,140	5	65	79	72	36	21
Qualified Health Visitors							
England and Wales							
1. Counties	4,138	6	80	90	81	42	11
2. County Boroughs ...	1,724	8	62	81	47	29	n
Scotland							
1. Counties	328	11	44	78	72	51	32
2. Cities and Large Burghs	512	5	55	64	37	32	n
Great Britain	6,702	7	72	85	68	38	9
Acting Health Visitors							
England and Wales							
1. Counties	1,319	n	45	69	80	30	72
2. County Boroughs ...	497	2	6	19	89	3	n
Scotland							
1. Counties	537	1	83	90	88	69	87
2. Cities and Large Burghs	85	2	36	54	54	25	25
Great Britain	2,438	1	44	63	83	30	54

NOTE: n=negligible.

TABLE 7

Percentage of Time of Health Visiting Staff Spent on Certain Duties

Category of Staff/Authority	Total W.S.E. of Staff	Administrative and Supervisory Duties	Ante-Natal	Other Maternity and Child Welfare	Schools	Tuberculosis	Other Home Visiting Duties	Home Nursing and Midwifery	Total
All Health Visitors									
England and Wales									
1. Counties	5,354	4	6	38	26	6	5	15	100
2. County Boroughs	2,193	6	5	44	34	4	7	n	100
Scotland									
1. Counties ...	862	5	5	23	13	5	4	45	100
2. Cities and Large Burghs	593	4	12	39	24	13	6	2	100
Great Britain	9,002	4	6	38	27	6	6	13	100
Qualified Health Visitors									
England and Wales									
1. Counties ...	4,083	5	7	45	23	7	6	7	100
2. County Boroughs	1,701	7	6	54	20	6	7	n	100
Scotland									
1. Counties ...	327	11	4	32	19	9	5	20	100
2. Cities and Large Burghs	511	5	13	40	22	14	6	n	100
Great Britain	6,622	6	7	46	22	7	7	5	100
Acting Health Visitors									
England and Wales									
1. Counties ...	1,271	n	3	18	35	1	2	41	100
2. County Boroughs	492	2	1	11	83	n	3	n	100
Scotland									
1. Counties ...	535	1	5	18	10	3	4	59	100
2. Cities and Large Burghs	82	1	4	30	40	4	5	16	100
Great Britain	2,380	1	3	17	39	1	3	36	100

NOTES: "W.S.E."=Whole-time staff equivalent.
n=Negligible.

out by Health Visitors. They show the percentage of staff engaged and of staff time spent on administrative and supervisory duties, ante-natal work, other maternity and child welfare, schools, tuberculosis, other home visiting duties and home nursing and midwifery. For the sake of comparison between groups of authorities, the total number of staff employed and the total whole-time staff equivalent are also included.

161. *Administrative Staff.* It is worth noting that the total number of administrative posts open to the rank and file of Health Visitors in their own profession was extremely limited—290 in the Counties, 170 in the County Boroughs, Cities and Large Burghs. Promotion opportunities in relation to all Health Visiting staff vary little between authorities, though they are slightly greater in the English and Welsh County Boroughs, where there was one administrative post to 16 Health Visiting staff, than in other areas, where there was one to 21 or 22 staff. Few acting Health Visitors were recorded as engaged in administrative duties. If promotion were limited to qualified Health Visitors only, the greatest opportunities would exist in the Scottish Counties, with one administrative post to 8 qualified Health Visitors. Elsewhere the ratio would vary from one administrative post to between 12 and 18 qualified staff. It will be observed that the administrative posts were not all whole-time and some senior officers were employed in home nursing and midwifery duties, reducing still further the chances for a Health Visitor without practical experience in those fields.

The clinic and home visiting duties of Health Visitors

162. *Ante-natal Work.* Except in the Scottish Counties a greater proportion of qualified than acting Health Visitors were engaged on ante-natal work. The survey confirmed the impression gained from the Nuffield Survey in 1950, that while many Health Visitors were still engaged in ante-natal work their contribution was small in terms of staff time. In the Cities and Large Burghs, however, twice as much Health Visiting time was spent on ante-natal work as in any other area. The extent of "combined" duties in the Cities and Large Burghs is too small to account for this excess which may reflect difficult housing and social conditions in some Scottish urban areas, and the special need for ante-natal care. There was also much variation in the proportion of time recorded for ante-natal work as between Health Visitors and others.

163. In England and Wales, Health Visitors were responsible for just over half the ante-natal work recorded. In the Scottish Counties they were shown as responsible for over three quarters, but it is possible that Health Visiting was credited with staff time spent on ante-natal work usually done by those midwives who were also acting as Health Visitors. In the Cities and Large Burghs, Health Visitors were shown as responsible for 82 per cent. of the work. The ante-natal work of midwives who were not Health Visitors, however, may have been included under "Home nursing and midwifery" instead of under "Ante-natal" thus apparently exaggerating the part played by Health Visitors in domiciliary ante-natal care. In part the high figure may be accounted for by the work of Health Visitors in hospital ante-natal care in certain Scottish cities.

164. *Other maternity and child welfare work.* It is clear that child welfare was the most important duty of Health Visitors both in terms of the number of staff and of the proportion of total Health Visiting time involved. It is interesting to note that, in the Counties, the amount of Health Visiting time given to this work still exceeded time given to any other branch, despite the fact that duties were generalised to a greater extent than in the County Boroughs and Cities and Large Burghs, where specialisation was more common. Acting Health Visitors were responsible for one-ninth of this branch of the work. There thus seems to be less reason now for the anxiety expressed as a result of the Nuffield survey of 1950 about the use of unqualified staff for this work, except in the Scottish Counties.

165. *Ancillaries.* The figures given by the authorities suggest that little or no nursing help was provided for Health Visitors in running clinics of all kinds. Counties employed only 208 nurses for this purpose and County Boroughs, Cities and Large Burghs employed only 189. The whole-time staff equivalent of the time given by these nurses to clinic duties was however only 158 in the county areas, 106 in the boroughs. In Scotland, on the figures returned, assistance at clinics was conspicuous by its absence. The home nurse/midwife group was shown as contributing small amounts of time which would not however, make a significant difference. The time of these clinic nurses was divided moreover between clinics of many kinds. We did not inquire into the employment of clerical staff or voluntary workers; but our evidence suggests that they relieved Health Visitors of

clinic duties probably not less (but not more) than in the 1950 Nuffield survey.

166. *School Health Service.* The distribution of staff and staff time on School Health Service duties is very different from that for maternity and child welfare. The School Health Service is clearly the second most important duty for all Health Visitors, but although a greater proportion of qualified than acting staff were engaged in the service, it absorbed more of the time of acting Health Visitors than any other duty, especially in the English and Welsh County Boroughs and, to a lesser extent, in the Scottish Cities and Large Burghs. The following table (an extract from Appendix III) shows the numbers of various categories of staff engaged in School Health Service duties, their whole-time staff equivalent and the proportion each category contributed to total staff time.

TABLE 8

Staff Engaged in the School Health Service

Authority/Category of Staff	Number	Whole-time Staff Equivalent	Percentage of total Staff-time
England and Wales:			
1. *Counties:*			
Qualified Health Visitors ...	3,354	943	59
Acting Health Visitors ...	1,053	442	28
School Nurses	136	127	8
Other Nurses	221	75	5
TOTAL	4,764	1,587	100
2. *County Boroughs:*			
Qualified Health Visitors ...	803	336	38
Acting Health Visitors ...	440	410	46
School Nurses	117	113	13
Other Nurses	70	28	3
TOTAL	1,430	887	100
Scotland:			
1. *Counties:*			
Qualified Health Visitors ...	235	62	52
Acting Health Visitors ...	475	51	43
School Nurses	3	3	3
Other Nurses	23	2	2
TOTAL	736	118	100
2. *Cities and Large Burghs:*			
Qualified Health Visitors ...	190	112	75
Acting Health Visitors ...	46	33	22
School Nurses	2	2	1
Other Nurses	5	3	2
TOTAL	243	150	100
Great Britain:			
Qualified Health Visitors ...	4,582	1,453	53
Acting Health Visitors ...	2,014	936	34
School Nurses	258	244	9
Other Nurses	319	109	4
TOTAL	7,173	2,742	100

It will be seen that relatively few nursing staff other than Health Visitors were engaged in the School Health Service. The proportion of all school nursing duties carried out by non-Health Visiting staff varied from nearly 16 per cent. in the County Boroughs to 3 per cent. in the Cities and Large Burghs. The extent to which Health Visitors were assisted by other nursing staff varied, however, widely between individual authorities, and in many cases such staff carried out considerably more than the average figure of 13 per cent. of all School Health Service duties. This suggests that there is considerable scope, particularly in Scotland, for reorganising School Health Service duties so that duties not requiring the Health Visitor's particular abilities can be carried out by less skilled staff.

167. *Tuberculosis.* As in the School Health Service, other nursing staff besides Health Visitors were involved in tuberculosis work. In the county areas 139 tuberculosis visitors and in the boroughs 115 such staff were employed. Numerically these tuberculosis visitors did not represent a large proportion of the staff engaged in tuberculosis work, but they contributed very considerably to the total time given to it. The following table, which is an extract from Appendix III, shows the numbers of each category of staff who carried out tuberculosis duties, their whole-time staff equivalent and the proportion of total time given by each category. As in the School Health Service a small number of home nurses and midwives were shown as engaged in tuberculosis duties and have been included as "Other nurses". Their time was probably spent in assisting at clinics; it may possibly have been included in error, however, and in fact may represent time given to the nursing of tuberculosis cases in their own homes. In any event the staff time involved was negligible.

Over one third of all Health Visiting staff gave some or all of their time to tuberculosis duties. Except in the Scottish Counties, a greater proportion of qualified than acting Health Visitors were so employed. The time given to this work by qualified staff was much greater than that given by acting staff. This is partly because a number of qualified Health Visitors were engaged whole-time on tuberculosis work, whereas no staff shown as acting Health Visitors were so employed; those not qualified as Health Visitors who were engaged whole-time on tuberculosis duties were counted separately as tuberculosis visitors.

On average, about 60 per cent. of the tuberculosis work in Great Britain was carried out by qualified staff. However, there were wide variations between authorities; for example in the Scottish Cities and Large Burghs qualified staff were responsible for 84 per cent. of the work, while in the English and Welsh County Boroughs they were responsible for only 46 per cent.

168. One point which is not fully brought out in the previous tables, or in the Appendices, is the extent to which tuberculosis duties were carried out by whole-time specialists (qualified Health Visitors and otherwise). An estimate can be made from information on specialist duties of staff which indicates that, in Great Britain as a whole, 289 qualified Health Visitors were employed whole-time on tuberculosis duties and were responsible for about 36 per cent. of the total time given to tuberculosis work. Together with the 253 tuberculosis visitors, therefore, they were carrying out about two thirds of this work. Specialisation was most complete

TABLE 9

Staff Engaged in Tuberculosis Visiting and Clinic Duties

Authority/Category of Staff	Number	Whole-time Staff Equivalent	Percentage of total Staff time
England and Wales:			
1. *Counties:*			
Qualified Health Visitors ...	1,714	283	66
Acting Health Visitors ...	390	13	3
Tuberculosis Visitors	132	127	29
Other Nurses	249	8	2
TOTAL	2,485	431	100
2. *County Boroughs:*			
Qualified Health Visitors ...	503	95	46
Acting Health Visitors ...	16	2	1
Tuberculosis Visitors	111	107	51
Other Nurses	113	4	2
TOTAL	743	208	100
Scotland:			
1. *Counties:*			
Qualified Health Visitors ...	188	27	56
Acting Health Visitors ...	369	14	29
Tuberculosis Visitors	7	7	13
Other Nurses	30	1	2
TOTAL	594	49	100
2. *Cities and Large Burghs:*			
Qualified Health Visitors ...	162	71	84
Acting Health Visitors ...	21	3	4
Tuberculosis Visitors	3	3	3
Other Nurses	70	7	9
TOTAL	256	84	100
Great Britain:			
Qualified Health Visitors ...	2,567	476	62
Acting Health Visitors ...	796	33	4
Tuberculosis Visitors	253	243	31
Other Nurses	462	20	3
TOTAL	4,078	772	100

in the borough areas; in the English and Welsh County Boroughs about 78 per cent. and in the Scottish Cities and Large Burghs about 73 per cent. of all tuberculosis duties were carried out by whole-time specialists. The position was not greatly different in the English and Welsh Counties where about two thirds of all tuberculosis work was done by specialist staff, but in the Scottish Counties, specialists were responsible for less than one fifth. Thus, whatever views may be expressed about the desirability of Health Visitors undertaking tuberculosis work as part of their general duties, the major part played by the whole-time specialists in all areas except the Scottish Counties is a fact to be reckoned with.

169. *Home Nursing and Midwifery.* These duties occupied about 13 per cent. of the time of all Health Visitors but only 5 per cent. of the time of qualified staff. No home nursing and midwifery was carried out by Health

Visitors in the English and Welsh County Boroughs, and very little in the Scottish Cities and Large Burghs. In the Scottish Counties nearly half of all Health Visitors' time was spent on these duties; by far the bulk of the work was carried out by acting Health Visitors.

In Great Britain as a whole Health Visitors on combined work were responsible for only a little more than 10 per cent. of all home nursing and midwifery. In the Scottish Counties however, they were responsible for 58 per cent. of the home nursing and midwifery work, thus indicating the importance of the "combined" nurse not only in the Health Visiting service, as at present organised, but also to the home nursing and midwifery services in those areas.

170. *Other home visiting duties.* The pro-forma sent to local authorities for completion under this heading indicated only the sub-headings "Mental health", "Mental deficiency" and "Health and welfare of the aged" and authorities themselves were asked to indicate further categories. Fifteen other distinguishable categories were mentioned including "Miscellaneous", besides a number of other fractions too small to count. It is difficult to assess the significance of some of these additional headings. Usually the numbers quoted were so small as to suggest specialisation; but they were not so referred to in the table specifically asking for this and the whole-time staff equivalents were usually negligible. Usually too the subjects were the sort in which Health Visitors might be expected to interest themselves, indeed unavoidably must in the course of their ordinary work, and they might well have been included in the main section of the table by most authorities. For example, time spent on duties associated with the children's department—or part of it—may have represented only visits for child welfare purposes to children in care. Some "care and after-care" may have arisen directly from work with mothers and children and school children.

171. If we assume, however, that "other duties" represented work that could not properly be classified under the main headings of the first part of the staff-time survey then it is apparent that such work, though often a concern of a large proportion of the Health Visitors, was not then a major factor in their working life. This is shown clearly in Table 10.

The total staff time involved was only 6 per cent. of the total time of all Health Visitors—though, of course, a larger proportion of time available for visiting would be absorbed. There was some variation between groups of authorities—most time being given in the County Boroughs and least in the Scottish Counties. More actual staff were employed in the county areas generally than in the boroughs, as would be expected from the greater degree of generalisation. More staff were involved in England and Wales than in Scotland. It is especially noteworthy that 4,577 Health Visitors were playing some part in the health and welfare of the aged but no less significant that their total contribution amounted to no more than 215 full-time staff. Another point of interest is the employment of 458 Health Visitors in connection with research projects; only the equivalent of the time of 19 Health Visitors was, however, taken up in this way.

172. *Other Workers.* As we have already said, the part of the survey which it was hoped would show what we might describe as the "competitors" of the Health Visitor (in the sense that they were working in the same field) was largely unsuccessful. We may assume that the figures were reasonably accurate in the parts relating to the traditional field—maternity and

TABLE 10

Health Visitors Engaged on Other Home Visiting Duties and Whole-time Staff Equivalent

Subject	England and Wales		Scotland	
	Total Number of Health Visitors	Whole-time Staff Equivalent	Total Number of Health Visitors	Whole-time Staff Equivalent
	1. Counties		1. Counties	
Mental health	258	2	158	2
Mental deficiency	725	11	240	2
Health and welfare of the aged ...	3,107	138	377	16
Care and after-care	1,197	39	66	3
Infectious diseases	427	10	121	6
Vaccination and immunisation ...	302	6	71	1
Home help (administration) ...	539	13	86	5
Children's department	846	25	56	n
Research	312	14	—	—
Miscellaneous (unspecified) ...	594	13	55	1
	2. County Boroughs		2. Cities and Large Burghs	
Mental health	129	3	n	n
Mental deficiency	189	7	n	n
Health and welfare of the aged ...	926	51	167	10
Care and after-care	271	24	n	n
Infectious diseases	216	19	43	2
Research	146	5	—	—
Housing	59	1	54	9
Venereal diseases	64	5	43	6
Home help (administration) ...	54	2	35	1
Miscellaneous (unspecified) ...	68	5	36	n

NOTE: n = negligible.

child welfare, school health and tuberculosis. It is interesting that in Great Britain as a whole 3 almoners and 22 other social workers were shown as holding administrative or supervisory posts with local authorities; only 2 social workers were shown under maternity and child welfare but 26 were shown under schools and 41 almoners and 26 other social workers were shown under tuberculosis. Inadequate as the returns are, it is clear that the situation is very different outside the traditional work. Counting all types of social worker together there were 659 (whole-time staff equivalent 357) engaged in mental health, 593 (309) in mental deficiency, 154 (47) in health and welfare of the aged; 20 (12) were shown to be active in care and after-care presumably otherwise than with mothers and children and 44 (34) were associated with the home help service.

School Health Service

173. Although the statement shown in Appendix VI showing staff engaged in the School Health Service, is, like the other sections of our survey, internally consistent it does not entirely match the figures shown in Appendix V, partly because it includes both clinic and visiting duties, partly because a less careful analysis of duties was thought necessary in this case.

(We were advised that it would be impracticable to secure figures for the whole-time staff equivalent devoted to each duty.)

174. The number of staff employed part-time in the service of the local authority and not otherwise employed is small—189 in England and Wales and 8 in Scotland; the qualifications of these staff are not known. The summary in table 11 below, excludes them. On the other hand the majority of staff were engaged both in school nursing and in other local authority service. This was very noticeable in the Counties—in England and Wales only 11 per cent. of staff were whole-time school nurses; in Scotland the figure was 6 per cent.

175. The total number of staff in England and Wales employed wholly or partly on school nursing duties (with the small exception mentioned) was 5,844; 4,025 were qualified Health Visitors and 1,819 were other school nurses. In Scotland the total was 1,040 of whom 438 were qualified Health Visitors and 612 were other nursing staff. Except in the Scottish Counties qualified staff outnumbered other staff; this feature was most marked in the English Counties. The actual staff numbers serve to show that there were differences in the emphasis laid on duties, as between types of authority and between qualified and acting staff. This applied particularly to the Counties and to the English and Welsh County Boroughs. Distribution of qualified staff among the various duties in the Scottish Cities and Large Burghs was rather more even; the figures give the impression that other school nurses—few in number—were used to supplement the general activities of qualified school nurses.

176. *School Nurse Visits.* Many of our witnesses indicated that the volume of visits by school nurses was very considerably less than the amount undertaken by Health Visitors generally. It is interesting to see from this table, however, that in England and Wales home visits were carried out by 90 per cent. of qualified staff in the Counties and 94 per cent. in the County Boroughs; in Scotland the figures were 98 per cent. in the Counties, but only 61 per cent. in the Cities and Large Burghs. This work seems to have been carried out without distinction by both acting and qualified Health Visitors; in England and Wales 75 per cent. of acting Health Visitors were doing home visits in the Counties, 72 per cent. in the County Boroughs; in Scotland the figures were 93 per cent. in the Counties, but only 36 per cent. in the Cities and Large Burghs.

177. *Other School Nursing Duties.* The following table shows the duties, other than home visiting, on which school nurses were engaged, and the percentage of staff (qualified Health Visitors and others) who were carrying out each duty. Staff engaged whole-time on specific duties are included.

The first five items in the table—medical examinations, cleanliness inspections, nurses' surveys and clinics—are clearly the most significant from the point of view of the proportions of school nursing staff (both qualified Health Visitors and others) employed on them, in all authorities. The relative importance varies with various groups of authorities and with the type of staff employed; medical examinations are clearly of great importance in all authorities, but there is greater emphasis on cleanliness inspections in Scotland than in England and Wales, and on nurses' surveys and clinic work in the English and Welsh County Boroughs than in the other authorities. In all authorities a greater proportion of qualified Health Visitors than

TABLE 11

Percentages of School Nursing Staff Engaged on Certain Duties

Duty	England and Wales				Scotland			
	Counties		County Boroughs		Counties		Cities and Large Burghs	
	A	B	A	B	A	B	A	B
Medical examinations	95	86	92	74	93	74	78	45
Cleanliness inspections	62	81	83	73	93	95	68	88
Nurses' surveys	66	43	77	63	60	57	52	41
" Minor ailment " clinics ...	46	41	52	76	60	35	63	60
Other clinics	38	30	43	66	47	25	45	35
Nursery schools and classes ...	17	13	49	42	8	11	34	21
Special schools	4	6	17	34	9	11	14	5
Health education in schools ...	13	4	12	9	21	15	10	3
Other duties	14	14	30	31	17	23	38	4

A = Qualified Health Visitors. B = Other school nurses.

" other school nurses " were engaged on medical examinations, nurses' surveys and at clinics (except in the case of clinics in the County Boroughs). It was otherwise with cleanliness inspections ; except in the County Boroughs a smaller proportion of qualified Health Visitors than " other school nurses " were engaged on this duty. The concentration of qualified staff on attendance at medical examinations, cleanliness inspections, nurses' surveys and minor ailment and other clinics is noteworthy since home visits by school nurses were relatively infrequent and the great bulk of their time was spent on these routine duties at schools and at clinics.

The other duties—nursery schools and classes, special schools and health education in schools—involved relatively few of the school nurses, except duties at nursery schools in the County Boroughs and Cities and Large Burghs, and at special schools in the County Boroughs. These two services would appear to be more developed in urban than county areas, and in England and Wales than in Scotland.

178. Few school nurses were employed whole-time on a particular duty. Of a total of 289 who were so employed, only 56 were qualified Health Visitors. The most important duty was attendance at clinics, carried out by 68 per cent. of the whole-time specialists, followed by attendance at special schools, on which 25 per cent. of the specialists were engaged. The remaining 7 per cent. of the specialists carried out other duties, of which audiometry was the most common. The use of specialist school nurses was more common in the County Boroughs and Cities and Large Burghs than in the County areas.

CHAPTER V

ANALYSIS OF THE DIARIES KEPT BY HEALTH VISITORS IN SIX SELECTED AREAS

179. In Chapter II we have described the discussions we had with professional people concerned in some way with Health Visiting. In six of the areas, visits were preceded by surveys of the work of a number of Health Visitors, carried out by independent observers. The areas where surveys took place were Newcastle and Northumberland, Glasgow and Ayrshire, and Cardiff and Glamorgan. There were some points of resemblance superficially between the areas. In each case there was an industrial city with a seaport and large suburbs, within a large county area in which there was at least some industry; only one of the county areas was predominantly rural. There was thus likely to be a broad similarity of health and welfare needs. In each of the cities there was a large University and closely associated with it a health visitor training centre with a reputation for efficiency. There, however, the similarities cease. There were differences in the administrative arrangements, no doubt owing their origin to natural regional differences. The Health Visiting services themselves were very different. For example, in Newcastle the school nursing and Health Visiting services were still not completely integrated; in Ayrshire only tuberculosis was specialised but Health Visiting was combined with nursing and midwifery; in Glasgow, maternity and child welfare, tuberculosis and school health were all separately staffed; in Glasgow also we saw staff who were seconded for housing work. In the remaining areas general duties work was done, but in Cardiff a number of Health Visitors were doing specialised after-care work.

180. In each of these areas a number of Health Visitors were asked to keep diaries during the first five days of an ordinary working week. The choice of weeks was discussed with the medical officers of health and was influenced partly by the limitations on our own time, partly by the need to fit in with local administrative arrangements and partly with the object of avoiding obviously abnormal weeks, e.g., the beginning of school terms. To some extent it was inevitable that the weeks should not be fully representative of work in the area; the organisation of Health Visiting often follows a monthly or fortnightly cycle and the kind of work that arises may vary with the time of year. The weeks themselves were, however, spread over a period of four months and most of the likely variations were probably covered (though not an emergency such as an outbreak of infectious disease or the special difficulties of a hard winter). In only one case was the work likely to be seriously affected by a periodic rotation of duties. In two cases a local holiday week had to be used but the main effect was only to reduce the number of Health Visitors who could keep diaries. Beside examining the diaries, the independent observers (whose reports are dealt with in Chapter VI) interviewed many staff who were not included in the survey to reduce the effect of any omissions, though this part of their observations cannot be analysed here.

181. The Health Visitors who were to keep diaries were partly taken at random, partly selected, but selection was not determined where it occurred

by the merit of the Health Visitor but rather by the desirability of avoiding the risk of missing work of a special character by random sampling. The arrangements unavoidably varied from area to area. In Newcastle and Northumberland one in five of the staff available during the week were taken at intervals from an alphabetical list. Of the 12 staff from Newcastle, 8 were doing general work, 2 were venereal diseases specialists, and 2 were school nurses; all 11 Northumberland staff were doing general duties and one of these was selected to represent entirely rural practice. In Glasgow, one in five of all maternity and child welfare visitors (20), tuberculosis visitors (8) and "housing inspectresses" (5) with one in ten of school nurses (4) were chosen similarly. Nine of the Glasgow Health Visitors taking part were not available for discussion afterwards and for comparability's sake, their diaries were not included in the summary. In Ayrshire selection was made from 72 combined duties staff (out of a total complement of 80); all 10 qualified Health Visitors in this group were taken, of whom 9 were included in the report together with one in six of the rest (10). In Glamorgan, 14 Health Visitors were taken from alphabetical lists in each of eight divisional areas. In Cardiff, 10 out of 34 general duties Health Visitors were taken, with 2 of the 9 part-time specialists (paediatrics and premature babies) and 4 of the 7 full-time specialists (psychiatric, diabetic and cardiac, tuberculosis and mental deficiency). Thus in all 77 Health Visitors who were doing maternity and child welfare work or substantially general duties took part in the survey, together with 23 specialists. The Health Visitors taking part were given instructions on how to complete the diaries, shortly before the selected week. They were allowed one practice day. They were expected to do an ordinary week's duty and no time was set aside for recording in diaries during the working day. They willingly spent a good deal of their free time on our behalf and we are most grateful for their help. The diaries used were modified slightly to suit local circumstances but were in essentials the same in each case. A specimen of a diary sheet is shown in Appendix VII. The diaries showed the time spent on various activities and the subject-matter of visits, including matter observed, whether or not dealt with at the time, and the kind of action taken or contemplated.

182. A general summary of the time-analysis is given in Appendix VII. This shows that, taking all in all, the working week in each case was much the same as described by the Nuffield survey, namely an average of 40·3 hours. It should be noted however that diarists were not asked to deal specifically with extra activities outside normal working hours. About 4·6 hours went on office work and 11·8 hours on clinics compared with a total of 10–12 hours on these activities (excluding incidental work at clinics) recorded in the Nuffield survey. The remaining time was divided between actual travelling time, actual visiting time and "other intervals" (almost wholly meals). Of the balance of 23·9 hours, "other intervals" accounted for 5·6, and travelling for 6·3 hours. Thus apparently on average Health Visitors in these areas did only 12 hours actual home visiting or 30 per cent. of their aggregate time.

Travelling Time

183. A further analysis of travelling time shows that, ignoring insignificant intervals such as journeys between neighbouring houses, the average duration of journeys for all areas together was 7·6 minutes. The following tabulation

shows the number of journeys falling within certain time-ranges, as between the Counties and the Cities and as between general duties Health Visitors (including maternity and child welfare Health Visitors) and specialists.

TABLE 12

Travelling Time. Number of Journeys Falling Within Certain Time-ranges

1. *Counties: Cities*

Authority	Total Number of Journeys	Total Time (hours)	Average Length of Journey (minutes)	Number of Journeys of certain durations (minutes)				
				0–5	6–10	11–15	16–30	Over 30
Counties	2,470	297·4	7·2	1,630	480	202	138	20
Cities	2,577	337·7	7·9	1,665	376	242	232	62
TOTAL... ...	5,047	635·1	7·6	3,295	856	444	370	82

2. *General Duties and Maternity and Child Welfare Health Visitors: Specialist Health Visitors*

Class of Health Visitor	Total Number of Journeys	Total Time (hours)	Average Length of Journey (minutes)	Number of Journeys of certain durations (minutes)				
				0–5	6–10	11–15	16–30	Over 30
General Duties	4,223	500·4	7·1	2,872	670	350	275	56
Specialists ...	824	134·7	9·8	423	186	94	95	26
TOTAL... ...	5,047	635·1	7·6	3,295	856	444	370	82

These figures include visits for nursing or midwifery purposes by combined workers in Ayrshire. About two-thirds of journey-durations fell in the range of up to 5 minutes and about a further sixth in the range 6–15 minutes. The average for Counties was slightly lower than for the Cities, but specialists, who are virtually non-existent in the Counties, inflate the City figures because they cover a much wider area. If account is taken only of journeys by general duties and maternity and child welfare visitors, the average for the Cities would be 6·9 minutes. Although it was noted, as in the Nuffield Trust's survey, that the average length of journeys was small, their aggregate effect was very considerable. A reduction in the average length of journey of 2 or 3 minutes would have made $1\frac{1}{2}$ to $2\frac{1}{2}$ more hours available each week to each Health Visitor for actual visits. The diary figures and evidence gained during our visits about the areas suggest strongly that a considerable advantage lay with those areas where better transport facilities were provided, or where Health Visitors worked from a base on the district and did not need to go daily or oftener to a central office. It is clear also that specialisation was rather more expensive in travelling time than general duties.

"No Access" Visits

184. As in the case of the Nuffield Provincial Hospitals Trust survey, a high proportion of "no access" visits was recorded—perhaps a little higher than the Trust figures because visits were counted as "no access" unless the client or a close relative was actually seen. While the Nuffield survey recorded 14 per cent. "no access" visits in County Boroughs the figures for Cities in our survey was 17 per cent., the specialists being a little more fortunate than the general duties visitors. The figure for county areas as a whole was 6 per cent.

The lowest figure was recorded by the combined workers of Ayrshire (4 per cent.) while in Glamorgan the figure was 11 per cent. and in Northumberland 5 per cent. This suggests to us that the determining factor is urbanisation and a high rate of "no access" visits may be extremely difficult to avoid in those circumstances. It is interesting, however, to note that a small County Borough not included in this series, which had a high "no access" rate, was able to reduce the figure considerably by re-timing visits to suit local customs. There may be possibilities of this kind in larger urban areas; no doubt evening visiting is done already in some areas.

Length of Visits

185. A total of 4,800 visits was covered in the diaries—4,162 by general duties, maternity and child welfare and combined staff and 638 by specialists. The average number of visits per Health Visitor was 48, but it varied between different areas and different classes of staff. It was higher in the Counties than the Cities, partly because of the inclusion in the latter of specialists who made fewer visits. This was particularly noticeable in the case of school nurses who only made, on average, 10 visits each. The percentage of visits falling within certain time ranges is shown in the following tabulation. The Counties and the Cities are shown separately, as are also general duty and specialist staff.

Generally speaking the visits paid in the Counties were longer than those paid in the Cities. This was partly because there were fewer "no access" visits, which are all counted among the 0–5 minutes time-range, partly because clinics were fewer, partly because for Ayrshire the home nursing and midwifery visits of combined nurses are included, but partly also because better transport was provided in the Counties. In the Cities, for example, 56 per cent. of visits fell in the range 0 to 10 minutes, and 44 per cent. were longer; in the Counties on the other hand 43 per cent. of visits were in the 0 to 10 minute range.

Visits by specialists were markedly fewer in number and generally much longer than any other except those of combined workers. If they were excluded from the City figures in the table, the average for general duties staff would be seen to be appreciably lower—11·3 minutes.

In Cardiff, for example, the psychiatric after-care visitor paid 13 visits of an average duration of 55·9 minutes while the tuberculosis specialist paid 10 visits of an average duration of 41·4 minutes. In Glasgow, school nurses paid 7·5 visits on average with an average duration of 14·5 minutes. The average number of visits by combined workers in Ayrshire was 71, the average length of which was 19·1 minutes (but this figure includes home

TABLE 13

Length of Visits. Percentage of Visits Falling Within Certain Time Ranges

1. *Counties: Cities*

Authority	Total Number of Visits	Average Length of Visit (minutes)	Percentage of Visits of a certain duration (minutes)				
			0–5	6–10	11–15	16–25	Over 25
Counties	2,461	17·1	14	29	21	19	17
Cities*	2,339	13·1	30	26	19	15	10
TOTAL ...	4,800	15·0	22	27	20	17	14

2. *General Duties and Maternity and Child Welfare Health Visitors: Specialist Health Visitors*

Class of Health Visitor	Total Number of Visits	Average Length of Visit (minutes)	Percentage of Visits of a certain duration (minutes)				
			0–5	6–10	11–15	16–25	Over 25
General Duties ...	4,162	14·6	22	28	21	17	12
Specialists*... ...	638	17·8	24	21	17	18	20
TOTAL ...	4,800	15·0	22	27	20	17	14

* No times were given for 27 visits, which are therefore excluded from the time-analysis.

nursing and midwifery). On the other hand, the average duration of all visits by the general duties maternity and child welfare group was 14·4 minutes—the average varying from 10·1 to 13·5 in the Cities and 12·3 to 19·1 in the Counties. The average number of visits was 54, also varying widely in number, the range being 44·7 to 55·0 in the Cities and 35·3 to 70·7 in the Counties. The above figures are heavily weighted in the case of the Counties by the visits paid by Ayrshire combined workers and need to be correlated with time spent on clinics and other duties. For example, full-time Health Visitors in Northumberland, with a considerably larger clinic commitment than Ayrshire combined workers, did half the number of visits (35·3 as compared with 70·7) but their average length was nearly the same (17·5 minutes against 19·1 minutes). Full-time Health Visitors in Glamorgan with still heavier clinic commitments averaged 52·1 visits lasting 12·3 minutes on average.

TIME SPENT AT "CLINICS"

186. "Clinics" was a term here used to classify all time not allocated to visits, travelling, office work or "other intervals", and thus included all visits to schools, hospitals, general practitioners and all conferences as well as the ante-natal and child welfare clinics which comprised the main indoor activity of general duties or maternity and child welfare workers. The total number of "clinics" recorded was 493, each Health Visitor showing an

average of 4·9 such items of an average length of 2·4 hours. Visits and conferences, etc., lasted less than 2 hours. The number of such activities falling in the duration ranges up to ½ hour, ½ hour to 1 hour, etc., was not widely diverse. Of clinics proper there were 322—nearly twice as many as visits and conferences. They mostly dealt with ante-natal and child welfare work; two-thirds of them fell in the time range 2½ to 3½ hours, the rest equally between 2 and 2½ hours and over 3½ hours. These clinics averaged about 4 to 5 per Health Visitor except in Ayrshire where the average was less than 1 and Newcastle where, in an abnormal week. the figure was only 2·8. Clinics tended to be a little shorter in the Counties.

Initiation of Visits and Contacts in the course of Visiting

187. We attempted to assess the extent to which Health Visitors' visits were initiated by themselves or at the instance of others, or the extent to which Health Visitors were concerned with other workers or agencies, during visits or as a result of visits. To do this the diaries were coded to indicate who had been responsible for the visit being made or had been concerned with the same family or was subsequently brought in. Any relationship with another worker or agency was termed a "contact".

"No access" visits were omitted because no contact or reason for visiting was recorded. Visits for purely home nursing or midwifery purposes (705) were also excluded. Of the remaining 3,538 visits, 87 per cent. were for purposes pre-determined by the Health Visitor herself, so far as the records showed. But this may be an over-statement. In fact an unknown proportion of visits recorded as made on the initiative of the Health Visitor were probably made on a reference from the public health department (acting, however, often at the instance of some third party). This certainly occurred in the Newcastle survey. Only 6 per cent. of visits were made at the request of the client and 7 per cent. at the instance of some other person, such as a neighbour, a general practitioner or a hospital. Since generally no difficulty in making contact with clients was found, however, it would be unreasonable to assume that, for example, clients were not requesting the services of the Health Visitor because they were unwilling to discuss problems with her. It seems more likely that matters on which clients wished to consult Health Visitors were dealt with at visits initiated by Health Visitors. The question remains open whether, if the frequency of regular visits were reduced, more requests from clients would follow.

188. While usually the Health Visitor was working alone she was in contact in many cases with a fairly wide variety of other workers to whom she referred or to whom she reported or with whom she discussed problems. The number of visits, however, on which such contacts occurred was 981 or only 28 per cent. of the total. In 21 per cent. of visits, there was one contact only; in the remaining 7 per cent. there were two to four contacts. Taking all Health Visitors together, in relation to all cases in which contact was made, the most important contact (38 per cent.) was naturally with the health or housing department, from whom problems were referred and to whom reports were made. The next most important contact was hospitals (23 per cent.), general practitioners (22 per cent.), schools (13 per cent.) and children's departments (9 per cent.). In the Cities general duties and maternity and child welfare staff made contacts in 18 per cent. of visits. Again the

most important contact was the health or housing department (in 33 per cent. of cases in which contact was made) and the next most important hospitals (23 per cent.), general practitioners (18 per cent.) and the children's department (10 per cent.). In Ayrshire, contacts were made in connection with 23 per cent. of the visits. Here in a considerably higher proportion of cases contact was with general practitioners (54 per cent.). Next came the health and housing departments (23 per cent.), schools (18 per cent.) and children's department (7 per cent.). In the other Counties a rather higher number of contacts was recorded—35 per cent. These two Counties also had the highest percentage—30 per cent.—of contact cases in which more than one contact was made. References to the health and housing departments were also the highest—45 per cent.—and rather higher in Glamorgan than in Northumberland. The next most important were schools (20 per cent.), hospitals (19 per cent.), general practitioners (only 16 per cent.) and children's department (12 per cent.).

189. The above figures are for general duties and maternity and child welfare workers only. The specialists generally speaking had a much higher contact rate with the exception of school nurses in Glasgow. For example, tuberculosis specialists made contacts in connection with 49 per cent. of their visits and contacts were made with the health and housing departments in 58 per cent. of these cases, with hospitals in 27 per cent. and with general practitioners in 20 per cent of cases. For all other specialists together the contact rate was only slightly lower at 43 per cent. As the nature of the work was usually hospital after-care, it is not surprising that in 51 per cent. of cases, the contacts were with hospitals and 33 per cent. with health and housing departments ; in only 16 per cent. of cases was contact with general practitioners. A much larger proportion of multiple contacts were recorded in specialist's diaries.

190. Comparison between individual authorities is extremely difficult. For example, Glasgow was the only area surveyed where tuberculosis was an entirely separate service ; here also, all references on housing matters were dealt with by separate staff. In Glamorgan the Health Visitors worked in divisional areas where centralisation of divisional health and welfare services made for easy contact with supervisory staff and other officers. In Ayrshire all Health Visitors seen were combined workers, and accordingly there was a higher rate of reference to general practitioners because of the much closer contact obtained in the course of home nursing and midwifery work. The overall picture, however, is in all essentials the same in all areas. It is noticeable that the Counties recorded a higher rate of contact than the Cities, suggesting a closer individual contact with local agencies or more intimate knowledge of them in the Counties, possibly because there were fewer agencies. Even the low figures of contacts with general practitioners must be accepted with some reserve because it is often doubtful whether actual contact took place except in the Counties ; probably most references consisted of advice to the client about general practitioners' instructions or advice to the client to visit the general practitioner. It appears, however, in these areas that co-operation of some kind between the Health Visitors and general practitioners occurred in some 25 per cent. of those cases in which some follow-up action by the Health Visitor was necessary (7 per cent. of all visits).

Nature of the Subject Matter of Visits

191. Many of the differences of opinion between Health Visitors and their critics seem to be in the construction placed on " maternity and child welfare ". We may illustrate by setting out the extreme views. On the one hand some assert that this work was and is no more than advice to expectant mothers and mothers with young children about matters affecting their bodily condition together with re-assurance to relieve the natural anxieties of mothers about their condition or their children's physical development. On the other hand the assertion is made that " maternity and child welfare " embraces all activities that may be undertaken on the occasion of visits to mothers and their children thus including in the term all psychological and socio-economic factors in pregnancy and the rearing of young children and all known factors in family life bearing on these matters. It is not contested, of course, that Health Visitors do in fact undertake the limited role implied in the first definition. The controversial issue is how far they contribute to the wider definition. They and their supporters naturally would not claim that they deal or ought to deal with those psychological or socio-economic aspects that call for the help of expert specialists. They do, however, claim that the official statistics misrepresent the scope of their work, if these are taken to indicate an interest merely in physical well-being. (We have referred to this possibility in Chapter II.) We thought it well therefore to attempt an analysis of the subject-matter of the diaries to isolate firstly those activities which fell within the most limited definition and thence to assess to what further problems the Health Visitors concerned might be making an additional contribution.

192. The matters dealt with at visits were divided into two broad groups —those which were concerned primarily with the physical health of clients and those in which the problem was predominantly of a psychological, social or economic nature. There is necessarily a psychological element, however minute, in all matters affecting physical health. This does not, however, invalidate the broad classification which has been adopted. Where a psychological problem of any magnitude was recorded, it has been counted as such ; where the advice given included a small but normal element of, say, reassurance, which could not reasonably be considered as a separate element from the advice on physical health, the subject dealt with has been treated as dealing with physical health.

193. The number of items of subject-matter dealt with at the 3,358 visits surveyed was 14,603. These were grouped together to form 57 classes of related subject-matter. Of all subject-items, 75 per cent. (10,991) fell into 10 of these classes, of which the content occurred most frequently in the diaries, that is, on 300 or more occasions. In the remaining 47 classes, subjects occurred on less than 300 occasions in all. The largest of the 10 classes was concerned with " physical health of children under five years " (31 per cent. of all items). " Physical health of mothers " came next (13 per cent.) and the third largest class was " infant feeding and dietary of young children " (8 per cent.). The rest of the 10 classes were all much smaller, accounting for between 2 and 5 per cent. of all subject-items. Two of these smaller classes dealt with the physical health respectively of " school children " and " other clients " (that is, other than mothers and children) in general

terms. Two others related to "specific illnesses of children" and "immunisation". Others were concerned with "physical and mental health of other clients", "mental, emotional and matrimonial problems" and "housing conditions".

194. To obtain a more significant picture of the classification of subject matter all subjects were further classed into two main groups arbitrarily headed "physical" and "psychological, social and environmental", ("psycho-social" for short). Under the first group came such items as the physical health of mothers and children, after-care visiting of clients and referrals to the nurse or doctor. Under the second heading came items in which the provision of services was involved or advice was given on some questions such as enuresis in children, problems arising from school work, the employment of mothers, emotional disorders in children, etc. The two groups were then sub-classified according to the principal client so far as practicable. In a number of cases, items were clearly related to children but could not be allocated between school children and younger children and these were grouped under "Children of all ages (unallocated)". There remained a further small group of items—all "psycho-social" in character —which could not be allocated with certainty to any class of client; these fell under a "miscellaneous" heading. The results are shown in the following table.

TABLE 14

Subject matter dealt with at visits in relation to clients

	Mothers and Expectant Mothers		Care of Children						Adolescents		Other Clients		Misc.
			Children under 5		Children of School Age		Children of all ages (unallocated)						
	Physical	Psycho-social	Physical	Psycho-social	Physical	Psycho-social	Physical	Psycho-social	Physical	Psycho-social	Physical	Psycho-social	Psycho-social
Cities ...	1,016	242	3,297	78	414	122	252	234	—	100	739	419	490
Counties	1,281	224	3,204	131	305	154	277	404	—	89	445	312	424
	2,297	466	6,501	209	719	276	479	638	—	189	1,184	731	914
TOTALS	2,763		6,710		995		1,117		189		1,915		914

195. In interpreting the table it must be borne in mind that the work of both general duties and specialist workers is included. Specialists are much more heavily represented in this survey than in the country as a whole; mostly, however, they were concerned with fractions of general duty work and they tended, therefore, to influence only the distribution of subject items among classes of clients. Moreover, one visit to a client may be represented by four or five subject items. The care of mothers and young children may, therefore, be over-represented. On the other hand the items ascribed to "children of all ages (unallocated)" probably refer mainly to work with children under five years. It seems not unreasonable to think that there was, however, a fairly close relation between the proportion of subject items and the number of subject-items and the number of visits paid to each class of client.

The table shows that some 65 per cent. of all subject-items were concerned with mothers and children under five years, the remainder being concerned with children of school age (7 per cent.), children of all ages (8 per cent.), adolescents (1 per cent.), other clients (13 per cent.) and miscellaneous (6 per cent.). If school children are excluded however mothers and young children account for nearly 70 per cent. of the items. If items relating to children of all ages are assumed all to have occurred in fact to children under five years the maternity and child welfare figure rises to nearly 78 per cent. of the total. This figure compares fairly closely with the official statistics of visits paid on behalf of the local health services according to which 83 per cent. were to mothers and children under five years in 1954.

Some 77 per cent. of all subject-items together were concerned with "physical" and 23 per cent. with "psycho-social" questions. The proportions varied, however, considerably with the class of client. If mothers and children under five are combined with children of all ages together "physical" items account for nearly 88 per cent. of the work. Items for all other classes of clients are almost evenly balanced, however, between "physical" and "psycho-social" subjects. This disparity is not surprising. Health Visitors probably visited as a matter of policy a high proportion of all mothers and did so fairly frequently, especially in the child's first year of life. They would visit mainly for educational purposes and without regard necessarily for the circumstances of the family. Visits to other classes of client on the other hand were more likely to be made not as a matter of routine but because of a known problem. If maternity and child welfare visits were concentrated on more difficult families the chances obviously are that the proportion of "psycho-social" items would rise substantially. While on the face of these figures, therefore, it appears that maternity and child welfare is numerically a matter largely of "physical" health education, it would be truer to say that such matters recur more often in Health Visitors' work with mothers than with other groups. A fairer picture of Health Visiting emerges from the statement that some 25 per cent. of the Health Visitors' work as a whole was concerned with "psycho-social" questions.

196. Local conditions and administrative practices must affect the picture presented by Health Visiting in any area. The services we saw in our visits, however, taken all in all are in our judgment at or above the average level. Although it could not be contended that the surveys described are statistically representative of practice in the whole country we think it not unfair to suggest that they give some indication of the general state of Health Visiting at the present time. We think they show clearly that Health Visitors are more concerned than many suppose with social action and in this role they are concerned with a very wide range of questions. It is nevertheless true that partly as a result of policy and partly by training the Health Visitors are predominantly concerned with physical health education. If as a result of policy changes their work falls more in the social field the development of their training must inevitably lead toward fitting them more for "psycho-social" work.

CHAPTER VI

SOME INDEPENDENT OBSERVATIONS ON THE WORKING OF HEALTH VISITORS

197. In Chapter V we have adopted what can be described as an arithmetical approach to the work of Health Visitors as recorded by themselves. This analysis took some little time and labour and could not be completed in the short period we were able to allow to the independent observers. The impressions they gained were, however, of considerable interest since they were formed by observers who were not closely involved in the immediate professional and other problems of the administration of the services concerned and who were fairly familiar with the area. Miss A. Eden who undertook the survey in Newcastle and Northumberland, is a lecturer in education at Durham University ; she has helped in the training of Health Visitors, child care officers and others. Miss J. E. Paterson who was the observer in Scotland is an almoner who was employed in the general practice teaching unit at the University of Edinburgh. Miss Frances Rees, who did the survey in South Wales, was until recently headmistress of Cardiff High School for girls and is a member of the Board of Governors of the United Cardiff Hospitals and the Cardiff Council of Social Service, among other activities. Each of the observers had the help of one of the Joint Secretaries, Miss M. H. Cook, who acted as adviser on professional matters. This Chapter summarises—so far as possible in their own words—the oral and written reports made to us by the observers. We regret that we cannot, for lack of space, reproduce the reports in full.

198. The observers were given general advice on the Working Party's objectives and they were asked in particular to consider the possibility of the Health Visitor as general purpose family visitor. Otherwise they were free to pursue the line of investigation that their training and experience suggested to them and to report as they saw fit. The first of the series was the survey in Newcastle and Northumberland. Later surveys were modified in the light of experience gained there, but generally the procedure was the same. The diaries were examined by the observer and her adviser. Each Health Visitor taking part was then interviewed informally and afterwards group discussions took place with selected Health Visitors. The formation of groups varied with circumstances. In the English areas, for example, Health Visitors with varying length of experience were seen together, while in Scotland groups were chosen from different services or staff with differing qualifications.

Newcastle and Northumberland

199. "The survey was undertaken as an attempt to find out from the Health Visitors themselves what their work is ; what they conceive their function to be, what difficulties they encounter in doing the job as they would wish, and what further developments in their functions they themselves would wish to see."

200. The Health Visitors themselves all had two things in common ; "they are trained nurses, with an interest in the social as opposed to the purely

technical side of their work. All, of course, began by taking the normal nurses' training in a hospital, some had added many years as staff nurse and sister. We asked them all why they had taken up Health Visiting; their answers hardly differed, even in phrasing. They said, while nursing, they had realised that patients in a hospital came from homes and belonged to families. They became curious about these homes and families, and realised how important a factor they were in the patient's condition and recovery. These are, then, people with a practical skill, they are proud of it and enjoy exercising it. None of them wished they had chosen a different route into social work; all said, many spontaneously and unprompted, that being known as a nurse encouraged people to confide in them.

201. "Alone of all the professional knockers-on-doors, Health Visitors do not wait till a breakdown is actual or imminent in a family before they visit. Theoretically, at some stage in the life of every family, they have a reason for a visit, and thus the entry to every house, at least, where there are or have been children. They do also of course deal with breakdowns and emergencies but the fact that very much of their work is straightforward affects their approach and should influence decisions about training.

202. "The fact emerged in every conversation with the Health Visitors that although their work is conceived of as medical, in practice they become involved in a host of non-medical problems. There are matters closely associated with health—like the obtaining of a home help, the arrangements with the Children's Officer for the care of children during the mother's stay in hospital in which people fairly naturally turn to an employee of the local health department, and generally, though not always, the Health Visitor's function is fulfilled when she has passed the message on to the appropriate department or worker in another field of the service; but there is another kind of problem, the ones touching human relationships. Here are some extracts from one week's diaries of this small group of Health Visitors:

> 'Relatives not interested in young child; family made to feel unwanted. Husband does nothing in the house. He thinks his wife is lazy and won't pay for home help.'
>
> 'Mother meek and uncomplaining, much subdued by much older husband who was late employer.'
>
> 'Mother very thin and run-down. Anxious to talk and confide in someone. Does not fight with her husband, but relations strained.'
>
> 'Rather strained atmosphere. Mother had words with mother-in-law. Talked with her for a while. Tension lessened.'
>
> 'Child born before marriage. Mother now in position to have birth legitimatised but has not done so. Urged her to change child's name before he commences school.'
>
> 'Mrs. . . . is meeting her husband secretly although she has a Court Separation Order against him. Very unhappy yet cannot see any solution to her problems. They must find accommodation to begin again without interference or help from in-laws. Mrs. . . . 's mother does not want a reconciliation; does not like son-in-law, but what she does not see is that her daughter will continue to have his children and she will have difficulty in supporting them. Husband is in arrears with weekly payments. I would like to see husband if possible.'
>
> 'Wife left husband taking child with her. Discussed case with husband who is willing to take wife back. Advised him to go and see his wife and child. Health Visitor in wife's present area now contacted.'

203. "It will be clear that some of these problems are insoluble. The Health Visitor's function is fulfilled if she listens sympathetically. As one of them said to us, 'The mothers feel they must talk to someone or burst. They can't let out to neighbours or relatives, but they know that we are safe, and won't pass on what they say.' But sometimes the Health Visitor is asked for advice, not just in general terms, but as touching important action." How able was she to give the best kind of advice, and how far did her training prepare her for this kind of work?

204. Miss Eden went on to discuss the extent to which the Health Visitor is actively concerned with co-operation, in the sense that she makes use of colleagues or they make use of her. She noted that the apparent purpose of the great majority of visits was maternity and child welfare. "Easier to assess is the degree to which Health Visitors make use of other social workers. In the county area, with sparse population and long distances to travel, the workers seem much more aware of the existence of each other. It was also our impression that the method of organisation of the work had its influence. Where the Health Visitors do their own correspondence and initiate their own contacts, not only is co-operation with other workers more frequent, it is also likely to be more fruitful. One Health Visitor said that her clinic had become a sort of centre in her district, and social workers of all kinds had the habit of dropping in.

"Following are some examples taken from the diaries of the sort of cases, involving co-operation with others, which come their way:

> 'Child under school age, parents legally separated. Child living with father, cared for by paternal grandmother. Very good home atmosphere. Mother of child shows no interest in making home with husband. Intends getting custody of child in near future. Grandmother and father afraid she will succeed. Grandmother sensible, active person, previously foster-mother for Church of England Children's Society. Badly wants to help baby. Promised to speak on her behalf to N.S.P.C.C. Officer. Contacted 4.50 p.m. Position confirmed. He will contact Health Visitor should any more Court action arise. Will keep in touch with grandmother.'
>
> '£60 in debt for furniture. Husband would like disablement pension in lump sum to clear. Payment refused. Is there any appeal? Husband referred to Coal Industries Social Welfare Organisation. Secretary's name and telephone number given.'
>
> 'Family in financial difficulties; urged to seek advice from N.A.B.'
>
> 'Unmarried mother with third child. Moral Welfare Worker again contacted.'
>
> 'Mother pregnant; no arrangements made for confinement. (After discussion.) Children's Officer will visit and arrange for children to be boarded-out.'
>
> 'Husband brutal and indifferent, drinks heavily. N.S.P.C.C. has visited as requested.'
>
> 'Visit as promised last week; difficult problem. Husband unable to control temper and of jealous nature; trouble arises after visiting his own family. Mrs. . . . very loyal to husband. Probation Officer contacted at request of family.'
>
> 'Mother and eldest child left father and two youngest children three days ago. Father off work looking after youngest child. Visit in a few days. Telephone Children's Department.'
>
> 'Increased rent; in receipt of National Assistance. Advised to apply for additional help from N.A.B. for rent. Telephone almoner regarding needs. T.B. after-care committee may help.'

'Child not eating; cries easily; appears to be unhappy at school just now; being bullied by other children on way home from school. Will see teacher when next in school.'

'Senile aged woman; no friends; very lonely. Contacted church visitor.'"

Miss Eden considered that co-operation of a high order was not, however, the rule. She drew the tentative conclusions that decentralisation of responsibility helped Health Visitors to make their own contacts but that training could influence co-operation greatly. She noted that when the need for consultation was obvious—as in the case of "problem families"—it was frequently recorded; it did not always amount to a combined attack on the problem.

205. Turning to the possibility of the family visitor of a "general practitioner" type, Miss Eden set out the assumptions that such a worker, firstly, would be a visitor and adviser not a practical worker in the same sense as the home help or home nurse and secondly that the work would be home visiting not administration. While the visitor must have a working knowledge of all the social work field with which she dealt, she would need to know enough to decide whether a job was beyond her competence and to know to which expert to turn. While she would need to have a good idea of the rules governing the provision of services—she would assess conditions and recommend—she would not decide or administer regulations. There would be no theoretical objection to her employment on behalf of any department on this basis. The problem was approached by asking Health Visitors what other work they felt capable (or wishful) of taking on or in what direction they felt their own abilities needed strengthening.

"We asked the Health Visitors in their group discussion to say what other work they would like to take over. Both groups were unanimous that they would not like to combine Health Visiting with either midwifery or district nursing. Most of the questions that we posed for group discussion were asked in order that we might see what grasp [the Health Visitors] had of the total field of social work. On the whole the impression gained was that such grasp was weak. Where they happened to have come across other workers who were co-operative, consultation followed naturally, but few of them seemed to ask themselves automatically in any situation, 'Now who is the person to talk to about this?'

"Knowing when your own knowledge is inadequate requires pretty high standards. In the group discussions the Health Visitors showed a commendable humility about the work done by most other workers but with one startling exception; every one of them affirmed without hesitation that they could do the work of the children's visitors. Yet an obvious blind spot in most Health Visitors is their ignorance of older children and especially of the problems of adolescence. There are good reasons why this should be so, and it is no discredit to the Health Visitors. Yet in reading the diaries through one is struck by the fact that whereas marital problems are frequently mentioned, hardly any of the Health Visitors seem to have been consulted about the older boys and girls. (One needs to bear in mind, that in the small families of today not many would have, at the same time, *both* an adolescent and a child under school age).

"But there is another qualification the family visitor needs to have, intangible, difficult to describe, even more difficult to legislate for; a wise understanding of human beings, a feeling for their sorrows and a tolerance for their failings, and an appreciation of the limits of her own power and usefulness. These qualities are to be found, over and over again, among Health Visitors. Some have spent half their working life in one district; they know their families intimately and have watched them grow up. To an original grace of personality they have added wisdom distilled from experience. Some of the youngest whom we interviewed give promise of becoming like them. Such people will always be valuable members of any profession, however good or bad their training may be."

"The greatest strength of the Health Visitor, regarded as potentially this family visitor, this general practitioner in social work, is that she has a practical skill and knowledge which is available for everyone and which mothers of families respect and value. She is not just a 'professional interferer'—she peddles wares which are in demand. This helps to remove the flavour of patronage which can easily spoil social work. Her greatest weakness, as revealed by these conversations, stems from the same origin as her strength. She is practical and competent, she can give straightforward answers to a large number of straightforward questions. This seems to lead her to feel that when things go wrong all that is needed to set them right is a little good advice. There seemed to us, among those with whom we talked, a somewhat naive faith in the efficacy of teaching."

206. Miss Eden continued that the difficulties of referral to the proper specialist were manifold. A very acute appreciation of the underlying situation would be needed to decide whether the family visitor should or should not refer a problem, or whether another worker should refer a problem to her rather than to a more specialised expert. Much might depend on experience and personality:

"Part of the difficulty is that any specialist called in to give expert help in a particular case, is apt to find herself faced with a situation involving the *whole family* and not just one member of it. This was clear in Newcastle in the work of the two V.D. specialists. One had been specialising in the following up of V.D. contacts for several years, and she had retained both an admirable perspective on the wider needs of the family and a self-effacing tact in calling in the help of colleagues when necessary. She modestly asserted that she did her job 'purely from the health point of view'. In our view she was doing high-grade social case-work with wisdom, devotion and balance."

207. Discussing with Health Visitors the nature of their training Miss Eden noted that:

"When we asked them what sort of problems they felt least able to cope with, and where their training was inadequate, there was an almost unanimous agreement, that they did not know enough about human behaviour—they wanted 'more psychology', 'more on child development', 'something to help us with marital problems'. (In this, of course, the Health Visitors are only like the rest of the human race. The point is that they are *aware* of their lack).

" There was unanimity on the following points.

(i) The initial hospital nurse's training is indispensable. Their nursing qualification is the essential passport into people's homes. As one of them said, ' It gives the mothers confidence in you. They don't mind asking you things if they know you've been a nurse '.

(ii) The special Health Visitors' training course is over-weighted on the side of anatomy and physiology.

(iii) Much more stress should be given to the school side of the work; there should be better teaching of child psychology, and some attention to psychiatry."

208. *Additional Notes.* Miss Eden also expressed personal views based on her whole experience of social welfare and student training which are of some interest. Her principal points were:

(i) Any weakness in co-operation and lack of a bird's-eye view of the social services could be remedied by efficient training.

(ii) Over-valuation of the beneficial nature of advice and over-readiness to give it could be eradicated in training—not by formal lectures but by carefully supervised practical work, which would teach students to examine their own actions and translate their good will into appropriate action. Especially, good case-recording was more than a necessary evil, it was one of the surest ways of producing good case-work.

(iii) In one respect, nurse-training was a handicap. " The kind of personal relationships made in a hospital are not typical of those in the world at large. The necessary obedience in technical matters of the young nurse to the sister can easily become a relationship of submission; and on the other hand a sick person is apt to be submissive to the nurse. The normal give and take between equals who respect each other may be almost lacking in the professional experience of a woman when she first takes up Health Visiting. Yet there should be just this kind of give and take between her and the responsible mother of the family."

(iv) The methods used in Health Visitor training courses tended to overlay the most important factor in learning—the emotional factor. Supplying students with a body of intellectual knowledge was not enough—and not effective if imparted by miscellaneous teachers not in touch with each other. The best results could be obtained—and the Health Visitors' own demand for help in understanding human beings would best be satisfied—by establishing a permanent school which would give Health Visitors the comprehensive outlook they needed and enable them to enter into satisfactory student-teacher relationships. The school must not be isolated from other related studies.

(v) It would benefit Health Visitors as a whole if the best among them could go on to further social studies—possibly a university diploma in social science—and help to leaven the main body with fresh ideas on the social side of their work.

Glasgow and Ayrshire

209. Miss Paterson was at some pains to show that while she found in both areas happy departments with efficient services, in both of which staff worked hard and well, there were marked differences in the kind of service given, stemming partly from the actual environment and partly from policy.

Glasgow

210. As regards Glasgow, Miss Paterson pointed out that a housing problem of exceptional difficulty was at the root of many social troubles, and had led to development along the lines of affording protection to the most vulnerable groups—mothers and children, tuberculous patients and families with insanitary habits. The public health department necessarily treated these groups separately and the possibility of a family service by one worker had not been seriously contemplated.

211. *Maternity and Child Welfare Group.* Of 15 Health Visitors seen, 13 had the professional qualification. A variety of reasons was given for taking up the work. Eight became interested in preventive work while student or trained nurses in hospital—but some had additional motives, such as a liking for work with mothers and babies or a dislike of hospital life. One returned to the work on being widowed; one had entered the service long before the war as a part-time worker. Three had taken up the work primarily because they had to live at home.

212. Regarding their training, "it was obvious that the necessity for general training and midwifery had never been questioned, and that no doubts as to this form of training being the only real preparation for the work had ever arisen. Part II midwifery was thought to be essential for maternity and child welfare work . . . no discordant voices were raised regarding the suitability of the Health Visitor training as a preparation for the work in hand. There were various comments worthy of note:—One Health Visitor said she regretted not knowing more of the social services now that she was working on the district. [Another] felt she had learnt a great deal from taking a course in parentcraft, especially about personality and family problems. [Another] while admitting the complete adequacy of the Glasgow course, felt it included too much information about 'anatomy and drains'. Three Health Visitors stressed especially the need for general hospital training, and one of them explained this by saying that the fully trained nurse is prepared by her training to make courteous and tolerant approach to the mothers. In addition, her experience of teaching junior nurses in hospital helps her to understand and have insight into the difficulties of inexperienced mothers, who resemble students in that they are undergoing a learning process."

213. In the main this group of staff were not essentially "family visitors"; "the Health Visitor in this area confines her interest to giving advice to the mother about herself and the care of her children. One Health Visitor did remark that the father of the family should be brought into the picture, and gave an instance of the great benefits that resulted from this. References to contact with grandmothers and other relatives were seen, and exceptional circumstances, such as the presence of a tuberculous patient in the house

were given. On the whole, however, the impression was that the Health Visitor envisaged herself as primarily a supervisor of, and adviser on, the health of mothers and young children, rather than as a family adviser.

214. "It would not be true to say that the content of the visit related solely to the health of mother and children, in the physical sense. Nevertheless, what social problems were noted seem to have been seen as a result of contact with mother and child primarily, and could scarcely be said to have been appreciated because of a comprehensive approach to the family. In a great many cases the health of the mother was noted as a problem, for which advice had been given, and this was commented on frequently in interviews. In a minority of cases, child guidance problems were noted and were found to have been dealt with in some cases by advice, in others by referral. Marital problems were brought under discussion at interviews, but in most cases it was found that simple advice had been given, and no real solution, where any was possible, had been investigated. Advice about material needs such as bedding took the form of telling the mother which agency to contact, and rarely was contact made with the agency by the Health Visitor. It was felt that, with few exceptions, the Health Visitor saw her function as an adviser in family matters, as that of providing a sympathetic audience to the mother, if she wished to obtain the emotional release of unburdening her troubles to an impartial witness."

215. Contacts within the Public Health Department were made as a rule when a specific problem demanded it and not as a matter of routine. Contacts with home nurses and midwives were fortuitous. There were limited contacts with outside agencies. Responsibility seemed to be regarded as completed when the referral had been made. As to relations with general practitioners, "it would probably be enough to say that both 'attitude to' and 'contact with' the general practitioner are conspicuous by their absence, especially the latter. On the other hand, there were many examples in the diaries of mothers being advised to consult the general practitioners about their own health problems. This did not lead on to any personal contact between the general practitioner and the Health Visitor; in many diaries advice given to the mother to come to the clinic about her own health was recorded. Special comment on this matter was made by six of the Health Visitors. One Health Visitor, though having little contact with general practitioners, thought, with reservations, that it would be helpful if she had. Two Health Visitors shared this view without reservations. One Health Visitor knew that her local general practitioners had their own child welfare clinic, and thought they had no greater measure of success than she had. [Another] told the investigators that general practitioners in her district occasionally asked for a special visit to be made. [Another] felt very strongly that she would like to work with general practitioners and found that general practitioners in her district contacted her. The accepted view seemed to be that it would be impossible to work with the many general practitioners concerned in the district of one Health Visitor.

216. "The question of fully combined duties, that is, with the home nursing and/or midwifery service, was raised by the investigators, but was ruled out of the discussion as impossible by all the Health Visitors, unless districts were made very small indeed, and, even with this proviso, as difficult and undesirable. This opinion appears to have arisen from a

feeling that curative and preventive work should not be mixed. The value of practical demonstration in district work was reluctantly admitted. The desirability of generalised duties with, for example, the tuberculosis Health Visitor, or sanitary nurse, was apparently a new point of view, at least to some of the Health Visitors. Feeling was definitely against it on the grounds that maternity and child welfare work would suffer, if tuberculosis or other visiting were undertaken". There was generally no concern felt about two visitors being concerned with one family; it might well be that families thought differently.

217. "Further information was sought about the Health Visitors' views on the adequacy of their training. Opinions expressed were that the course for the Health Visitors' certificate contained too much instruction on anatomy, physiology, and sanitary legislation, and not enough about human problems. The teaching of relaxation exercises for expectant mothers should have been included in the course to obviate the necessity for the introduction of a physiotherapist.

218. "This led on to discussion about the overlapping of duties in the health field; two Health Visitors felt that mothercraft should be taught by the Health Visitors as this would avoid the introduction of a worker who taught this and nothing else. There seemed to be a sharp division of opinion about generalised duties. One Health Visitor felt that there were 'too many people going into the home'. This was followed by a suggestion from another Health Visitor that the quality of the service given is not so good, if the workers are not specialists. Four Health Visitors replied that generalised duties would mean less overlapping and that mothers might discuss their problems more fully with one visitor. The further step of combined Health Visiting and home nursing and midwifery duties was felt to be impossible, in an urban area, and had obviously not been thought of as a practical proposition.

219. "The group was asked to state what in their opinion constituted the greatest problem in the work. All agreed that this was housing and that other problems arose mainly from bad housing conditions. The problem of many mothers, that of bringing up a family in very cramped conditions, was commented upon, together with the difficulty of teaching family health under these circumstances.

220. "The last point taken up by the investigators was that of the difficulty in the actual approach to the mother at the visit. The general opinion was that too much detail was required for the records and that this made the Health Visitor's task difficult and her reception uncertain".

221. *Tuberculosis Group.* Five Health Visitors were interviewed, four of whom had taken the Health Visitors' certificate in order to do tuberculosis work, while the fifth had found the only vacancy was for this work and now fully accepted it. "They all felt that full nurse training plus the Health Visitors' certificate was an essential and satisfactory preparation for this type of work. Some doubts were expressed as to the adequacy of information given about welfare measures. One Health Visitor said she felt she had learnt a great deal as the result of a recent refresher course.

222. "The investigators felt that this type of work seemed to make it easier for the Health Visitor to have contact with the whole family, than for the maternity and child welfare Health Visitor, if only because of the

necessity of knowing who were the contacts of the patient. Mention of members of the family other than the patient who were seen at the visit, seemed to indicate that the visit was more in the nature of a Health Visitor-family contact than a Health Visitor-patient contact. For example, there were frequent instances of the mother of the patient being advised about her own health, and some of rehabilitation plans being made, or personal problems being discussed, in the case of the patient's brothers and sisters. These Health Visitors seemed to be better aware of family circumstances than were their colleagues, family structure, housing, occupation and income being rather more fully described. There were numerous references in the diaries and in discussions to suggestions about rehabilitation problems, financial problems, and disturbed personal relationships within the family. The role of sympathetic listener was again evident.

223. " Contacts were mainly the chest physicians at clinics, the sanitary inspector's department, and the home help service. Frequent contact with the local authority laundry service was seen in the diaries. These Health Visitors have the power to assess the family's needs for the use of this service on compassionate grounds and to recommend. Contact with other Health Visitors was made when a problem arose rather than as a matter of routine and again it was found that two Health Visitors could be involved with one family without contact between them being made. Contact with the home nursing service appeared to be largely fortuitous. Contact with family agencies outside the health service was not extensive during the week under review and again the advice was to a great extent that of telling the family which agency to make contact with about a specific problem. There seemed to be little direct contact with the general practitioner. Patients or members of their families were frequently advised to consult their general practitioners. Often, however, the chest physician was asked to undertake contact with the general practitioner, where the patient's condition required that certain information should be conveyed to the doctor visiting regularly. Two Health Visitors said that they knew the general practitioners in their districts well and one of them remarked on the fact that in her district the general practitioners seemed to urge their patients to accept the help and advice of the Health Visitor. This she had discovered in the course of her visits. In her district, general practitioners often telephone the clinic to contact the Health Visitor and offer lifts in their cars to visits. On the question of overlapping with other workers, both within the public health department and extraneous to it . . . an older Health Visitor felt that the present position of specialised visiting could not be rectified, but that newly-trained workers should be started on generalised duties. Another member of the group thought that, given the right conditions, *one* visitor for all Health Visiting duties in a district would be best. As to co-operation with other agencies such as the hospital almoner, the two younger Health Visitors felt that there was conflict in welfare plans when both almoner and Health Visitor were looking after the same patient. The older Health Visitor said that the work of the almoner and Health Visitor should be complementary ".

224. *School Health Service Group.* " The work was confined to routine clinic duties, attendance on the school doctor, and the giving of remedial treatment for the ailments of school children. There was little evidence in the diaries of contact with parents except for explanation of treatment or

arrangements for it. Visits to the homes of children were usually made in order to contact defaulters from the school clinics. Some time was spent on lectures on hygiene, especially to children going to harvest camps. This work on the whole could not be regarded as a family service and the emphasis was on curative rather than preventive nursing duties ".

225. *Sanitary Nurses.* A feature of the Glasgow services were the sanitary nurses or housing inspectresses, twenty-five in number, who were seconded for work mainly with the housing department. None hold the Health Visitors' certificate. The original idea it was understood was to pursue the Octavia Hill system of housing management, but without reference to rent collection. Good housekeeping was to be taught and families helped to make good use, according to their abilities, of the facilities provided for them by the local authority. Five sanitary nurses were included in the survey and four were interviewed. " All had general training and considerable hospital experience, and one had been matron of a maternity hospital. She and one other nurse were widows and had taken up this form of work on the death of their respective husbands, having children at home. Part of the reason for taking up this form of work had been the possibility of doing it without further training being necessary. The necessity for full nursing training was specially mentioned by one visitor, who felt that the confidence that was vested in a trained nurse made the approach to health problems very easy. None of the nurses seemed to feel that the Health Visitors' certificate was a prerequisite for the work. Whatever the motive for taking up the work originally may have been, all workers found great interest and satisfaction in it, and did not wish to change.

226. " There were manifold possibilities of contact with the whole family and part of the satisfaction expressed by the nurses in their work arose from this very point. Great interest in the family as such was expressed by all and there were references in all the diaries to the advice given on health problems to all members of the family.

" The duties of these nurses seem to fall into three groups, (*a*) visits on behalf of the sanitary inspector's department to families in the lowest grade of ' new ' house, that is slum clearance houses, with a view to protecting the property of the local authority and to improve their standards sufficiently to become eligible for the next grade of ' new ' house ; (*b*) visits to elderly persons unable to maintain standards of cleanliness and living in insanitary conditions ; and (*c*) cleanliness inspections in schools in their districts, combined with follow up visits to the homes of children found at these inspections to be dirty in person and/or clothing or infested with vermin. The sanitary nurses are perhaps in a fortunate position in that their visits are to the household under (*a*) and (*b*) (above) rather than to one age group or one patient in the household. This perhaps makes observation and appraisal of family circumstances easier. On the other hand the nurses, of whom two were housewives and mothers, and of whom all were mature women, may have had a deeper interest in family affairs than their younger single colleagues in other departments of the work. All appeared to have a keen interest in and sympathy with elderly and crippled tenants, and with problem families.

227. " Sanitary nurses are responsible to the sanitary inspector for the area, and to the divisional medical officer of the local authority. Contacts

with Health Visitors are made when a problem arises and not as a matter of routine. Little mention was made of contact with the home nursing service. Like the tuberculosis Health Visitors, sanitary nurses have power to recommend families for use of the compassionate laundry service. In school cleanliness inspections, contact is made with the headmaster, or senior woman teacher of the school. Little contact with outside agencies in other branches of their work was mentioned, except with the children's department. There was virtually no contact with the general practitioner. The only contact seems to be at second hand, general practitioners referring elderly people in insanitary conditions to the sanitary inspector, who asks the sanitary nurse to visit.

228. "No strong views were expressed on the desirability of combined duties, and it was not felt that overlapping with Health Visitors, home nursing service or other workers was a serious problem.

229. "These nurses gave the impression of acting very much on their own with remote supervision. This type of work with its necessary inspection of cleanliness in the home from an authoritative viewpoint could have been very uninteresting, but appeared, on the contrary, to be full of opportunities for the nurse to work as an independent agent in making welfare plans for the family".

Ayrshire

230. The report emphasised that Ayrshire was largely a rural county with two large towns and a few small burghs. Mining and agriculture were the important industries and there was some fishing. Housing was satisfactory on the whole. The people did not move often and a picture was presented of a permanently stable population with local family contacts not subject to the sophisticated influence of large cities.

231. Of twenty nurses who kept diaries, nineteen were interviewed, of whom nine held the Health Visitors' certificate. All were doing combined work; all were registered general nurses, midwives and Queen's nurses. All appeared to have chosen the work because of a liking for it, though some special reasons were offered as well. All appeared to work with a fair measure of independence of supervision, without day to day contact with supervisors.

232. "The nurses' appreciation of family and social circumstances was very good on the whole with some notable exceptions. In some cases, appreciation of social circumstances was expressed in general rather than particular terms, in the sense that views on social phenomena rather than on the problems of individual families were described to the investigators. The description of family circumstances by the nurse in the diary varied very much. In the case of 10 nurses (7 with the Health Visitors' certificate and 3 without it) descriptions were well made, with attention paid to family structure. In the case of the remaining 9 nurses (2 with the Health Visitors' certificate and 7 without it) description of family structure and circumstances was limited.

233. "Very few contacts with other agencies were recorded. This is probably due to the fact that in a stable community where family ties are strong, there is not the same need for the introduction of help from outside the family circle in times of illness and trouble. The main contacts noted, or mentioned in interviews, were with school teachers, Children's Officer,

home help service, and with the tuberculosis Health Visitor. A most happy relationship with the general practitioner seemed to exist in all districts. In some cases the general practitioner had his own ante-natal clinic at which the nurse assisted, in others the general practitioner had his own surgery in the local authority clinic. Close and friendly co-operation, with almost daily discussion of the work was evident, with very rare mention of friction.

234. "There seemed to be some dissatisfaction at the number of hospital confinements, which in the opinion of the nurses, could well have taken place at home because housing conditions are in general satisfactory. Only one of the nurses who recorded their number of cases for us had a large load (72 per year). The rest ranged from 2 to 33 cases per year. Most of the nurses appeared to find this branch of the work interesting, and regretted being used largely as maternity nurses rather than as midwives.

235. "The impression of the investigators was that whereas most nurses without the Health Visitors' certificate felt their work in public health to be adequate, the more enlightened among them realised that this further course of study would enrich their work very much. Of those nurses who had undertaken this further course of study, almost all admitted that their vision was enlarged and their work was very much enriched by the additional knowledge and experience.

236. "Attitudes towards the question of combined duties were interesting to the investigators, who found the position could be summed up as follows:

Nurses with a strong leaning towards public health (4 with certificate—1 without)	5
Nurses with a strong leaning to district nursing (1 with certificate—7 without)	8
Nurses apparently considering both duties as fairly equal (4 with certificate—2 without)	6

237. "It would appear that in the majority of cases the nurse feels reasonably able to do public health work without the course, but after taking it, sees the reasons behind some of the points of public health nursing that she appreciated only intuitively in the past. Some nurses appear to swerve from their allegiance to district nursing as a result of qualifying, but just as many considered the two duties to be complementary. Those who had the certificate seemed to be agreed that there was no need for public health work to suffer, if combined with general nursing duties, but that at certain times, public health visits had to be postponed.

238. "In the opinion of the investigators, as good a family service was given by the nurse without the qualification, for general needs, but, in appreciation of social problems and in recognition of the need for health education, the better qualified nurse seemed to be in a stronger position. The work seemed to be very well done, the comparatively uncomplicated needs of this largely rural community being very adequately met. That these needs could be provided for by nurses employed on combined duties without the Health Visitors' certificate is a distinct possibility; on the other hand there is no doubt that the less tangible but all important problems of the work are met with much greater insight by the nurse who is fully qualified to undertake all duties. The great variety of work experienced by nurses engaged on combined duties is apparently found to give considerable

interest and satisfaction, and almost all of those who had undertaken the special qualification were firm in their conviction that whereas the additional knowledge had greatly influenced and improved the standard of the service they were able to give, they would not wish to forsake combined duties for specialised work in Health Visiting".

239. *Additional Notes.* Miss Paterson considered separately the possibility of development of a family visitor service. In her view, as an almoner with institutional and community health service experience, there would be much to commend such a development. It would represent a considerable and valuable extension of the role of the Health Visitor, if the latter could undertake it. Many families within the orbit of no specialised social worker, might stand in great need of such a service. She thought it questionable whether this was yet possible in either Glasgow or Ayrshire. Such work demanded not only the development of a satisfactory relationship between the family and worker—as it were, on a basis of equality—but also complete awareness of and co-operation with all workers concerned with the family. In Glasgow, however, the necessity for concentration on vulnerable groups created a strong tendency to concentration on the client within the family rather than the family itself; Health Visitors themselves could hardly avoid this. Again, the great urgency of dealing with neglect of health and the volume of work inevitably must tempt visitors to urge and direct their clients into healthy courses rather than persuade and co-operate. Two or more authoritative advisers concentrating, perhaps without co-ordination, on a family might well overlook less tangible problems that one worker standing to the family in a permanent suggestive relationship might readily discover. Another requisite of family service would be awareness of other agencies. This was also largely undeveloped. In Ayrshire, conditions were decidedly easier. The greater stability of the population must be a favourable factor. But the more important factor from the point of view of development was the existence of a basic comprehensive service in the form of combined duties work. Co-operation with other agencies would be comparatively simple since they were few; the link to the agency that was a common factor in all families—the general practitioner—is already forged. At present, however, here too a really deep understanding of personal and social problems within the family or between the family and community rarely existed. Health Visitor training would be essential. The Queen's Nurse training alone would not be enough. Finally, an even greater measure of independent activity must be possible to and properly used by the visitor who aspired to become a health and welfare adviser to the whole family.

Cardiff and Glamorgan

240. In Cardiff, service was reported to be given in six areas served by six main clinics. Health Visitors were based on clinics serving the area in which they worked but they had weekly meetings at headquarters. In Glamorgan, there were nine divisions each in the charge of a divisional medical officer. A divisional supervisor was responsible for Health Visitors in each division; the service for the County was under the eye, of course, of the County Medical Officer and Superintendent Health Visitor. Some of the Health Visitors were based on the divisional offices, some on clinics, and some worked from their homes. In Cardiff, 16 Health Visitors of a

total of 52 staff kept diaries, including six engaged wholly or partly on specialist work. In Glamorgan, 14 Health Visitors kept diaries. All these were interviewed singly or in groups; in addition a group of divisional supervisors was seen. Miss Rees reported :—

241. "We found that in several cases our Health Visitors had first been attracted to this work when they were nursing patients in hospital and realised that much illness could be prevented. In other cases there was a reaction against what appeared to be the somewhat confined circumstances of a hospital and the desire for district work. In a few cases it was obviously the attraction of living at home, always a strong motive in Wales. All seemed satisfied with the Health Visiting course as a preparation and several mentioned as especially useful those parts relating to human behaviour and family and social relationships. But it was generally agreed that while formal training is a good preparation, one goes on learning the work 'on the job'. All were emphatic that the general nurse training and the midwifery qualifications were essential, not only as the guarantee of professional knowledge and skill, but as the basis of confidence in the 'nurse' as the family visitor, and of the reliance on her integrity. Several of those whom we interviewed mentioned the fact that the imparting of confidential information was often prefaced by the words 'I can tell you, you are a nurse'.

242. "The primary purpose of the majority of the visits recorded in the diaries was maternity and child welfare. The records showed that during the visits the Health Visitors not only advised what should be done but often demonstrated how to do it, e.g., bathing and dressing the baby, sterilising utensils, treating minor ailments, dealing with matters connected with feeding. We found in the interviews that the Health Visitors emphasised the importance of caring for the mother, since she was the one likely to be most affected by any disability in the family, and was often apt to neglect her own needs. The following are two examples from the diaries of practical help to the mother. The first is a visit made to a family at the request of the home help department. There were five children, four under school age. The Health Visitor had found the mother two weeks previously in need of medical attention; she had treated her, put her to bed, summoned the family doctor, and arranged for a home help to come immediately. After two weeks the mother discharged the home help because she could not afford to pay her. The father worked regularly but the mother said he did not help in the care of the children. The Health Visitor arranged for a part-time home help. She made an appointment for the mother to attend the family planning clinic, and was intending to see the father and to suggest that he should give more help with the children. In the second case the visit was made at the request of the family. The mother wanted to have her baby immunised and asked if this could be done by the mobile unit as she was too nervous to attend the immunisation clinic. The Health Visitor tried to find out why the mother was so nervous. The mother volunteered the information that she had previously attended the psychiatric clinic for one year, and still had attacks of extreme nervousness. She said that her husband's relations had been unkind to her since this baby's birth, refusing to speak to her. [There were three older children, the youngest being 7 years of age.] She also said that she had had a prolapse for some time and had just refused a hospital bed because she was feeding the

baby: she was suffering a good deal of pain. The Health Visitor made arrangements for the mobile immunisation unit to call. She decided to see the mental health liaison Health Visitor about the mother's past history. She urged the mother to attend the child welfare clinic on the housing estate in order to meet other mothers with young children. She arranged for the mother to see the woman doctor at the clinic about her own health.

243. "We found other cases of maternity and child welfare visits where there were no problems about the mother and infants, but where the Health Visitor's help was sought with regard to other children of school age, as in an example of a boy aged seven years who was at home ill when the Health Visitor made a routine visit to see his 3 year old sister. The boy was subject to bilious attacks. The mother said he had formerly attended the paediatric clinic and had received tablets. She said that the attacks were becoming more frequent and severe. The Health Visitor learnt that there was no family history of migraine: that the boy was happy in school and that he had a good appetite. The mother said that his vision was blurred at times: he could not always see the blackboard. The Health Visitor arranged another appointment at the paediatric clinic, and decided to test his vision at school. She said that she would arrange with the teacher for him to sit in front if possible. She advised the mother to contact the family doctor if necessary.

244. "In both areas we found that the Health Visitor was a means of liaison between home and school and in the interviews we discussed this aspect of the work. The routine visits to schools in Cardiff afforded opportunities for frequent contact, and we were told of requests to the Health Visitor to 'explain to the teacher' or a promise by her to 'look at' a boy or girl in school with some minor ailment or slight physical abnormality, for example, a Health Visitor was told by a mother that her boy, aged 7 years, turned his toes in as he walked. The Health Visitor said that she would look at his shoes in school. Although the instances recorded dealt mainly with children in junior schools, there were a few examples of older boys and girls; one a case of a boy who had stolen money from a box at home and had also taken a fountain pen from school. The mother confided this to the Health Visitor, and asked her to see the teacher in school, and also said she would like the probation officer to call. This was arranged. In another case the mother told the Health Visitor that her daughter aged 15 years, attending a secondary school had become resentful at home (apparently because her 17 year old sister had married and her husband had come to live in the family home) and had begun to stay out late at night. The Health Visitor saw the girl in school and discussed the matter with the head mistress who knew the circumstances.

245. "Whether the Health Visitor called primarily for 'maternity and child welfare' purposes or for some other purpose—as a specialist or as a general duties worker—we found that members of the family other than the client visited were frequently involved. For instance in our interview with a Health Visitor engaged part-time on the asthma survey we asked her whether in her visits to asthma patients she was consulted about other members of the family. She gave us some examples and we quote one in which she was consulted by or about every member. She visited the home of a child attending the asthma clinic in order to report on the home conditions

to the clinic doctor. She found the house to be damp and she sent a report to the sanitary inspector. She had a talk with the mother about the patient's general health and the symptomatic treatment which had been prescribed at the clinic. The mother then asked her about whooping cough immunisation for a child aged four years and about treatment for warts for another child of school age. The mother also said she was troubled about her daughter aged 18 years who had a cold and cough; she had been under observation at the chest clinic though she was not a notified tuberculosis case. The mother wished her to go to the chest clinic again and the Health Visitor gave her the times of the clinic sessions. The father came home from work during the visit. He was a gastric patient who attended the gastric clinic, and he asked the Health Visitor for some information about diet.

246. "We also discussed the care of the family as a whole with other specialist Health Visitors. Those responsible for mental health and mental deficiency said that in the cases with which they dealt the other members of the family might suffer more than the patient with whom they were immediately concerned, and that their care was for the family as well as for the patient. We noted one case in the diary of the mental health liaison Health Visitor which had been referred to her by a Health Visitor doing generalised work in the district. It had been in the first place a maternity and child welfare visit. The baby was five months old. The mother, aged 47 years, was suffering from depression after the birth of her child. She had seven other children and during the last pregnancy they all had whooping-cough, and since her confinement three of them had had glandular fever. The baby had had bronchial pneumonia, and the mother herself had had influenza. There were financial difficulties: there was a sum owing to the City Treasurer for the last home help. National Assistance was not available but the Health Visitor referred the case to the Catholic Service Society which might help. The mother was also worried about the cost of the eldest boy now attending a grammar school. The Health Visitor obtained the appropriate form, helped the mother to complete it, and sent it to the education department with a covering letter requesting a clothing grant for the boy. She also arranged appointments for the mother for a post natal examination and for the baby to be vaccinated.

247. "We have quoted these examples from the diaries to illustrate our clear impression that although the Health Visitors first visited a family for some specific purpose or to see one member of it, their work had grown to embrace the health of the family as a whole. Moreover, once confidence had been established they found themselves involved in other aspects of family life, some of which had a bearing on health such as relations between husband and wife, parents and children, grandparents and grandchildren (ofter now living in the same home). Difficult housing conditions and overcrowding caused strained relationships in the whole family, extending beyond the household visited. We found that such difficulties were often confided to Health Visitors in the hope that they could give practical help. This they were to some extent able to do, in co-operation with the housing department and the sanitary inspectors.

248. "We found that cases of long illness might involve families in financial worries and that in such cases the Health Visitor might approach the National Assistance Board about maximum allowances, advise on the

question of free meals for children at school, seek help from voluntary bodies (Family Welfare Association for temporary financial help and general care, Women's Voluntary Services for clothing and 'meals on wheels' for old people). One Health Visitor, responsible for tuberculosis after-care, had approached the rating authority about payment of arrears of rates, and a furniture firm (threatening to reclaim the furniture) about easier hire-purchase payments, in order to relieve the anxiety of two of her families.

249. "There were other cases in which the cause of unhappiness was emotional and where immediate and tangible help could not be given. In these the Health Visitor might be not more than a sympathetic listener. How far she could give comfort or advice in a delicate situation would appear to depend on personal qualities enriched by experience of life rather than on any professional skill. We could not, of course, assess the extent of her success in individual cases.

250. "We considered the Health Visiting service in both areas to be generally adequate to deal with the kind of problems described to us. Often, it was clear, very good work had been done. We found that the Health Visitor was often the link through whom the benefits of the statutory and voluntary welfare services were brought to the notice of the families she served. In Cardiff the co-operation between those engaged on specialist duties and those doing generalised work was good. We were much impressed by the quality of the specialist Health Visitors, and it would appear that the chance to do at least part-time specialist work had a stimulating effect on some of the abler Health Visitors. In the actual matter of visiting, their value was not only in their specialised knowledge but in the fact that they were able to give more time to individual cases and/or to visit more frequently than an area Health Visitor could hope to do.

251. "In Glamorgan there are geographical differences which considerably affect the manner of working of the Health Visitor. The method of co-operation with other social workers and the extent of collaboration with the general practitioners varies considerably in the different divisions. In one fairly large compact area where the other services were housed in the same building and the Health Visitors were able to make direct contact, we thought the co-operation to be very good. In other districts where the Health Visitor was working in her home community and where she was personally known to the general practitioners and to other workers in local government there was happy and informal co-operation about some families. In some divisions [with more scattered areas] any necessary contacts must unavoidably be made through the divisional medical officer or the divisional supervisor: this appeared to be the most suitable or the only practicable method. The effectiveness of some of the work in Glamorgan, in the mining valleys for example, lies in the fact that the Health Visitors are working in their home communities, in full sympathy with local traditions. Some of them, though adequately equipped in the professional sense, have more limited experience of life outside their own neighbourhood, but this is counterbalanced by the fact that they are more readily accepted among their own people, and that they are doing the work of their choice in the place where they would choose to do it. We felt that these Health Visitors were enjoying their work and doing it competently. We received the

impression that the satisfaction in the work is greatest in those divisions where the greatest measure of initiative and independence is encouraged in the Health Visitor".

252. *Additional Notes.* In subsequent discussion with the Working Party Miss Rees stressed the importance of leaving the Health Visitor free to do her own work as a responsible worker, and of giving her the necessary facilities. Specialisation offered an incentive to better work.

253. Her experience as a headmistress suggested that there was scope for recruitment direct from school, especially secondary modern schools. Too much importance should not be attached to formal educational qualifications at the expense of personal qualities; some developed their intellectual powers much later than others.

254. She noted that Health Visitors thought their nurse training especially valuable in establishing relationships. She saw nothing to suggest an over-didactic approach or inability to 'learn without asking' in the course of their visits.

CHAPTER VII

PRESENT AND FUTURE STUDENT HEALTH VISITORS—CHARACTERISTICS OF STUDENT HEALTH VISITORS

255. To find out so far as possible what numbers and kinds of students are coming forward for training, we asked training centres to tell us how many had entered training (and their age distribution) during the period 1949–50 to 1953–54 and to tell us in rather more detail something of the kind of students entering training in 1953–54. We asked them to exclude students from overseas who did not intend to practise in England, Wales or Scotland. The difficulties in compiling the return were considerable for many training centres and we are grateful for the time and trouble which they gave to the production of figures which despite some inconsistencies can generally be regarded as valid. The main figures are summarised in the tables at Appendix VIII.

Number and age distribution of Health Visitors entering training

256. The tables show that over the five year period, 3,334 students entered training in Great Britain, an average of 667 every year. The average conceals, however, a sharp fall between 1949–50 and 1951–52 from 774 to 632. Numbers have since fallen very slightly.

The reasons for the fall in the number of students after 1951 are obscure. It may be that a relative improvement in the pay and conditions of hospital nurses and a tendency to lengthen courses had their influence. It may also be that the figures for earlier years were artificially high. In order

to prepare for their responsibilities in the National Health Service many authorities were anxious to have their existing unqualified staff trained. This source of students naturally fell away in due course.

The present figure—623—falls short of the 10 per cent. replacement rate which the Standing Conference of Health Visitor Training Centres in England and Wales considered would be the safe minimum. In fact, however. the age distribution of the Health Visiting force is such that this percentage would be an over-estimate in the next few years; the effective pass rate of students entering the qualifying examination, either at their first or subsequent attempt, was so high that this number of entrants to training was sufficient to produce a slight increase in the total number of Health Visitors.

257. The age group in which recruitment has mainly occurred has been the 25–35 year group. Almost the whole of the decrease has been felt in this group. The recruitment of younger and older age groups has been relatively constant—12 to 14 per cent. of recruits were under 25, mostly in their 24th year and 22 to 25 per cent. were over 35, mostly in the age group 35 to 40 years. Married and widowed students were distributed fairly uniformly among the older groups; the numbers of these students shows a slight tendency to rise, but in no year did they exceed 15 per cent. of the total.

Qualifications of Health Visitor Students

258. All students complied with the main alternative requirement[1] that they should be registered general or sick children's nurses and should hold at least Part I of the Central Midwives Board's certificate. Of those who entered in the last three years of the survey 75 per cent. held both parts of the midwifery qualification. This would be partly due to the fact that the first part alone does not qualify for practice as a domiciliary midwife and there is thus a strong incentive to complete training whether or not the student intends to practise. It was also clear that the possibilities of domiciliary social work only became apparent to many students during their domiciliary midwifery experience.

259. Of the entrants in the last three years only some 35 per cent. had the school leaving certificate or some apparently equivalent qualification. In 1953–54, however, according to a more detailed survey, one centre was able to recruit such students for all its 39 places and the average for all centres was about 44 per cent. It has been suggested to us that the rising trend might continue and that this might be due to an improvement in the standard of student nurse recruitment following the difficult period of the war and immediate post-war years. It is noteworthy that two-thirds of the candidates who held a school certificate or its equivalent had also obtained the full midwifery qualification, and that 40 per cent. of midwives also held a school certificate. The proportion of Health Visitor students holding an educational certificate is higher than in the nurse trained population as a whole; this suggests what a review of nurse training figures also tends to bear out—that a higher proportion of better educated women complete further training than those who are less well educated. It may be

(1) There is no alternative method of entry in Scotland.

that so far as education is a criterion, Health Visiting is drawing to an increasing degree on the more able nursing and midwifery staff, whom their employers would most desire to retain.

260. Reports on 615 students in training in 1953–54 showed that only 32 had an educational qualification higher than the general certificate of education. About the same number had some other vocational or professional qualification that might be of value to them as Health Visitors. Others had trained for an additional part of the register of nurses or had some special nursing qualification or were on the roll of the Queen's Institute of District Nursing. Information was obtained also about the nursing experience of these students. 152 had had experience of hospital work before taking nurse training, 176 had had hospital experience only, in nurse training and afterwards, before becoming Health Visitors; a further 11 had taken Health Visitor training immediately after completing nurse training or the first part of the midwifery examinations; 341 had public health experience after their hospital training before becoming Health Visitors (in 56 cases for a period of less than 6 months)—mostly it seemed as midwives or as clinic nurses waiting for a course vacancy.

261. Reports were obtained about 468 of these students as to whether they had had any non-nursing experience. Of these it was known that 158 had worked only as nurses either in hospitals or in the public health field. The remaining 310 had had a wide range of employment experience, including incidentally office and secretarial work (47 per cent.), domestic work (22 per cent.), shops and personal services of other kinds (15 per cent.), and others—including teaching, agricultural or veterinary work, social work and service with the armed forces—(33 per cent.); 17 per cent. had had experience in more than one of these categories. The work ranged from the highly skilled to the unskilled and employment of this kind had covered up to 15 years in some cases.

262. Some information was obtained about the point at which the decision to take up Health Visiting was made by 529 students. Only 5 per cent. of these had reached this decision before they took up student nurse training, 22 per cent. decided after a period of nursing in hospital and 61 per cent. chose after having had some experience outside hospitals. Clearly the hospitals themselves are not the main recruiting ground for Health Visitors; it may be that the revision of the syllabuses of the General Nursing Council may help to interest more students at an earlier stage. No attempt was made, in this simple form of questionnaire, to go very deeply into the motives of students in taking up Health Visiting. Where a reason was given it was generally the desire to work with people in their homes rather than in hospitals or an attraction to social work, and particularly Health Visiting, often through contact with Health Visitors or their work. The second reason was given by the few who entered nurse training with Health Visiting in mind and especially also by domiciliary midwives. It seems likely that the Health Visitor is her own best recruiting agent.

Future Student Health Visitors

263. We gave some consideration to the possible educational level of the future pool of Health Visitors assuming that they will require to be registered general nurses. For this purpose the General Nursing Council for England and Wales kindly made arrangements for an examination of a sample of their records, as at 1st January, 1955. The Council inaugurated an index of student nurses in 1947 including particulars of educational qualifications and this has been maintained since, the records being transferred to the register on completion of training. No records of such qualifications are available before 1947.

264. We were advised that the general characteristics of the nursing profession in Scotland would be likely to be the same. We did not, therefore, trouble the General Nursing Council for Scotland.

265. First of all, a rough check was made on a selected sample of training schools of various sizes and in various areas to ensure that there was a high probability that educational qualifications would be entered on the records sent to the General Nursing Council. We were satisfied that transcription of records by the General Nursing Council itself to its index was complete. It might be expected that student nurses would not understate their qualifications when applying to training schools. It seems likely, therefore, that the final records in the index or the register are representative.

266. Secondly, a check was made of a sample of one in twenty of all nurses whose names were entered on the register since 1947. A total of 8,042 cards were examined, of which 6,220 related to nurses who entered training before 1947 or trained abroad.

267. Of the balance of 1,822, 32 per cent. had the school certificate or qualified for matriculation. Of those now aged 21–24 years, 37 per cent. had these qualifications; the figures for those in the age group 25–29 years and 30–34 years were 29 per cent. and 22 per cent. respectively. These differences are regarded as statistically significant but it is problematical how far it can safely be assumed that they reflect differences of intellectual ability to benefit from academic training; older nurses may have had less desire or need to obtain these qualifications. Furthermore, the figures may be influenced by the fact that the period covered was one of peak recruitment when lower selection standards may well have been set. It is probably not unreasonable to assume that some 30 per cent. of registered general nurses within the field of recruitment during the next five years will be of such a standard that they could have passed the former school certificate or matriculation examinations.

268. Thirdly, an analysis was made of one in twenty of the records of nurses on the index of student nurses. This survey deals with future nurses who may be entering into Health Visitor training in five or six years' time (assuming that no effective action is taken to lower the normal age of entry to Health Visitor training). A total of 3,233 cards were examined and particulars taken from 2,160 cards excluding 63 nurses training for the general part, 742 who entered before 1952 and withdrew from training and 268 who had entered for training before 1952 but who could not be allocated from the records to a particular year.

From the cards used, covering students (excluding nurses already on some part of the register) who entered into training during 1952–1954 inclusive, 1,656 students were still in training and 514 had withdrawn at some stage. Of those in training 586 (35 per cent.) had either the general certificate of education, school certificate or matriculation and the rest had no qualifications. Of those who withdrew 107 (21 per cent.) had such an educational qualification. The information obtained from the cards indicated that failure to complete nurse-training was more common among students without some recorded educational qualification than among the educationally qualified.

269. The replacement of the school certificate by a general certificate of education makes almost impossible a comparison of the academic attainments of holders of one with those of holders of the other. This means that a direct comparison cannot be made between registered nurses and student nurses, or between student nurses who entered training in the different years. This is so because the general certificate of education can be taken in any number of subjects and because the pass mark in the examination is somewhat higher than the pass mark for school certificate. We do know, however, that holders of either of these qualifications were, in the great majority of cases, educated at secondary schools of the present day grammar school type, and that in the case of the general certificate of education they have stayed at school at least until they reached 16 years of age.

Since a general certificate of education can be awarded in one subject only, it is reasonable to assume that a greater proportion of school leavers aged 16 and over (and hence of student nurses) will hold a general certificate of education in the future, than held a school certificate in the past. This is borne out by the analysis of the index. Over the three years for which the educational qualifications of students entering nurse training were examined, the proportion of all student nurses who appeared to hold an educational certificate increased, and at the same time the proportion of general certificates of education in the total of educational certificates held also increased.

270. It seems likely that in the future, assuming no change either in the school leaving age or in the age at which a pupil may sit for the general certificate of education, some 40 to 45 per cent. of student nurses will hold a general certificate of education. Not all pupils who have been educated to the age of 16 will hold a general certificate of education, although we are told most sit for the examination, and it is therefore reasonable to make some allowance, say an additional 5 per cent., for student nurses who have been educated at least to the age of 16, but who do not hold a formal educational qualification. This means that in future we can expect that some 45 to 50 per cent. of student nurses will have been educated at least to the age of 16, and that the majority of these will hold a general certificate of education.

CHAPTER VIII

OUTLINE OF THE PRESENT ARRANGEMENTS FOR TRAINING HEALTH VISITORS

271. A full account of all aspects of the arrangements for training Health Visitors would make a lengthy document. We intend here to set out only the facts most relevant to our study.

272. There are separate though similar arrangements for England and Wales and for Scotland. In England and Wales, as we have noted, since 1948 all Health Visitors engaged by local health authorities are required by Regulations to have the prescribed qualifications, though the Minister of Health may dispense with this requirement. Tuberculosis visitors are required to be Health Visitors, or to be State Registered Nurses on the general part of the Register with at least three months' experience at a sanatorium, hospital or dispensary for the treatment of tuberculosis. Such Regulations have not been thought necessary in Scotland. The Minister of Education has, however, made Regulations covering England and Wales only which require nurses engaged after 1st April, 1945, for the School Health Services to be Health Visitors, if this is possible, and except in the case of those "employed solely in a school clinic, or on duties of a specialist character".

The Examining Bodies

273. In England and Wales, the body controlling the examination of Health Visitors has been since 1925 the Royal Sanitary Institute (now the Royal Society for the Promotion of Health). This body has a wide field of interest and has responsibilities in connection with other professional trainings, notably that of the sanitary inspectors. The Society is responsible for the setting of papers, all arrangements for examinations and the issue of the certificate referred to in the Minister of Health's Regulations. The Society is consulted by the Minister about the approval of courses of training. Its functions are exercised through a Training and Examination Committee, composed of 15 members of the Council, 3 representatives of Government departments, 8 representatives of training centres and 2 of Health Visitors' organisations. A sub-committee is responsible for setting examination papers. A panel of examiners is maintained, mainly composed of medical officers of health, maternity and child welfare medical officers together with senior Health Visitors and Health Visitor tutors. Separate papers are set for every examination. Questions are drawn from a pool formed from suggestions from the panel.

The arrangements for the examinations have recently been revised. The written part is taken by the student at the training centre. Examiners mark papers at home and markings are standardised at a meeting before the oral examinations, which are held at a convenient centre for the purpose. Examiners work in teams of three—a medical officer of health, a maternity and child welfare officer and a Health Visitor. They mark the papers of about 12 candidates between them and examine the same candidates orally in the course of a morning. They have with them the course tutor's report on each student. Ten examinations will be held each year, as hitherto, which previously unsuccessful students may also take.

274. In Scotland, the arrangements are slightly different. The Royal Sanitary Association has been the central body responsible for the examination and certification of Health Visitors since 1932. Arrangements for the examinations are made by a sub-committee which includes University representatives as well as medical officers and Health Visitors. Examiners work in pairs—a medical officer or University representative and a Health Visitor. Each pair examines 8 to 10 students, the oral examination being held in the afternoon of the day in which the written examination is completed. One examination is held annually at one of two centres, with one "re-sit" examination if necessary.

275. The pass rate in both countries is extremely high, in the sense that almost all candidates who are prepared to persist in their attempts to pass the examination eventually succeed. In England and Wales for example only about 80 per cent. of candidates pass at any particular examination and some 85 per cent. succeed at the first attempt; but the percentage of students who are successful ultimately, however, amounts to some 97 per cent. of all entrants.

Courses of Training

276. Courses are approved in England and Wales by the Minister of Health and in Scotland by the Secretary of State in consultation with the examining bodies. Courses are provided at 26 centres in Great Britain, three being in Scotland and one in Wales. At one centre three courses start each year but at most centres only one course is held annually.

The minimum length of a course is 6 months; the majority of the 26 centres however, provide courses of 9 months' duration and only five courses in England and the three courses in Scotland are shorter than 9 months. One course lasts 10 months and one 12 months. The number of training places available is about 800—but as Chapter VII indicates this number has not been taken up for some years.

277. The organisation of centres is not usually the sole responsibility of one body but in most cases the local health authority is the dominant partner. In twelve centres, courses are run by the local authority or authorities in association with a University. The latter in many cases acts as general adviser and supplies lecturers and sometimes accommodation. In some cases, however, responsibility rests wholly with the University or the University is the dominant partner in joint arrangements. At nine other centres, courses are held at technical colleges. One of these—Battersea Polytechnic—provides a course independently of employing authorities or professional bodies. At two other technical colleges, courses are run by the local education authority; at three by the local health authority; at another, jointly by health and education authorities; and at two the sponsoring body is the Queen's Institute of District Nursing. At the remaining five centres courses are wholly the responsibility of the Royal College of Nursing (one) and local health authorities (four).

278. Arrangements for the selection of student Health Visitors are varied and to some extent depend on the arrangements for the organisation of training. In some cases where a University is largely responsible for organisation, selection may also rest entirely with them—after "pre-selection" by

local authorities of candidates whom they are prepared to sponsor. In others, the University or other training body may accept all students put forward by local authorities as sponsored students. This method of selection, which does not permit adequate comparisons to be made, and which may be influenced by a serious shortage of trained staff, is subject to some criticism from training centres. In some cases selection is carried out jointly by the training institution and local authorities who wish to sponsor students.

The Standing Conference of Health Visitor Training Centres Approved by the Minister of Health

279. The Conference includes representatives of all Health Visitor training centres in Great Britain except one. Each training centre has two representatives, one of whom is usually the medical officer or education officer in general charge of the course and the other the Health Visitor tutor or sometimes the Superintendent Health Visitor. The Conference concerns itself with all matters affecting the training of Health Visitors, including the selection of students, the syllabus of lectures, arrangements for practical work, the conduct of examinations and organisation generally. It nominates training centre representatives to the Training and Examination Committee of the Royal Society for the Promotion of Health. The Conference meets regularly in London and takes a lively interest in all matters affecting the work of Health Visitors and is concerned that the training courses should be adapted and revised to meet the needs of intending Health Visitors, as these needs change with developments in the public health field. Originally constituted as a temporary measure to facilitate the re-organisation of Health Visitor training after the last war, the Conference has in fact become a permanent feature of training organisation.

The Finance of Training

280. Exchequer assistance towards the cost of training centres is provided in more than one way. In England and Wales, grants are paid by the Ministry of Health to training centres towards the cost of tuition, to reduce the fees payable by the students. The grants amount to £15 per student for a course of less than 9 months and £25 for longer courses. Any expenditure incurred by local health authorities in connection with a training centre ranks for Exchequer grant under the National Health Service Acts both in England and Wales and in Scotland (where all centres are wholly a local health authority responsibility). The Ministry of Education also contributes to the cost of training by way of grants to local education authorities on expenditure on technical colleges, some of which take part in the training of Health Visitors, and on further education awards to Health Visitor students and partly by way of a grant to the Royal College of Nursing for its educational courses generally. By far the larger part of Exchequer expenditure on Health Visitor training is met by the National Health Service, however.

281. Local authorities play a large part in the financing of Health Visitor training. In addition to co-operating in the organisation and financing of training centres, they also assist individual students to attend a training course. Information about assisted training schemes was requested in the

Working Party's survey of all local authorities in Great Britain. Of 195 authorities who provided information on this subject, 148 had schemes and had between them assisted 2,781 Health Visitors during the five years 1949 to 1953. The total number of students entering Health Visitor training during this period was 3,354. Details of 151 schemes were provided; three authorities had more than one scheme. Two thirds of the schemes provided for the payment of a salary to the student, the remainder for a fixed grant to cover maintenance. The salary paid varied between less than £150 per annum to £420 per annum—the latter being the minimum salary of the qualified Health Visitor at the time of the survey. By far the majority of the schemes provided for a salary of between £200 and £315 per annum, and the most common arrangement (66 schemes) was a salary of £315 per annum or three-quarters of the Health Visitors minimum salary—an arrangement recommended by the Minister of Health before the war.(1) In a few cases the salary covered the first year of the Health Visitor's employment, including the period of training; thus after qualifying the Health Visitor would be expected to work for a short period at less than the negotiated salary rate. This is a survival of an arrangement also officially approved in earlier times,(1) under which, part of the financial assistance provided during training would be in effect an advance of salary. Where maintenance allowances were paid to students they varied from less than £100 to over £300. The most common arrangements were an allowance of £100 to £200 for a 6 month course and £150 to £250 for a 9 month's course; but some of the smallest allowances were given in respect of the longer courses.

Nearly two thirds of local authority schemes were known to provide for payment of tuition fees, and in one third examination fees were paid for the first attempt. Some other assistance was sometimes given, for example, travelling expenses whilst doing practical work, uniform allowance or a book grant.

282. The majority of these schemes were organised and financed by health departments, the cost incurred ranking for grant under the National Health Service Acts, in the same way as net expenditure on training. In a few cases responsibility lay with the education department, or the two departments jointly. On the whole, the schemes organised by health departments provided for more generous financial assistance than those organised by education departments. Grants from education departments were usually on much the same lines as that department's normal further education grants.

283. There are other sources of financial assistance to intending Health Visitors, but very few students were helped by them. For example, the British Red Cross Society provide a few scholarships which are available to nurses to take the Health Visitors' training course. In Scotland, the Queen's Institute of District Nursing provides financial assistance for up to twenty-four Queen's Nurses each year to undertake Health Visitor training. For twenty of these nurses, this assistance is provided out of funds largely subscribed for the purpose of training nurses in the domiciliary services by local authorities in Scotland, who are therefore, indirectly, financing the training of these students.(2).

(1) Circular 879; Health Visitors; 28th March, 1928.

(2) Few Scottish authorities make direct provision for assistance; scales of assistance are generally low.

Part III. Review and Recommendations

CHAPTER IX

A GENERAL REVIEW OF THE PROBLEM

284. We have examined relevant opinion fairly exhaustively, testing its validity against local experience. We have collected what statistical information could usefully be assembled in the time available. Before proceeding to our conclusions it may be useful to take stock of the main factors as we now see them and to re-state the problems on which our advice is asked. It is necessary at the outset to point out the limitations. We must, for example, write in terms of generalities while recognising that the wide variations likely to occur in local circumstances, in resources in staff of various kinds and in individual ability will make a literal application of principles temporarily undesirable or impracticable in some areas. It is also necessary to emphasise that our Terms of Reference confine us to the consideration of the Health Visitors' role in the health services and we have not, therefore, considered the possibilities of service beyond that field other than by way of co-operation. It is impossible, moreover, to foresee how, in fact, health and related services will develop or what new needs will arise, calling perhaps inevitably for new methods of working or new types of worker. Our recommendations must, however, be forward looking and not entirely based on past experience. Having briefly examined that experience we shall need to consider what changes can reasonably be expected.

285. Health Visiting emerged in the first decades of this century from the activities of a variety of public health workers as specialised health education directed to mothers and young children in their own homes. Having its origins in voluntary effort, it is now almost exclusively a public service. Its object has been primarily to persuade, guide, advise, direct mothers in ways of health and it undoubtedly has had great success. The same kind of need for health education has been manifest in the schools and school nurses who undertake such work are expected to be qualified Health Visitors. In these, the main fields of employment, the Health Visitor is primarily concerned with the healthy and her object is to preserve health and watch for early signs of departure from the normal; she visits her families at intervals and is not associated necessarily with crisis. Health Visitors also have, however, responsibilities in relation to communicable diseases generally, and in particular for the tuberculosis visiting service. Here they are concerned with the situation produced by an illness; they come on the scene when help is required and leave it when help is no longer needed. In addition, a small proportion of all Health Visitors act, in country areas—especially in Scotland—as nurses and midwives, or, more accurately, the latter act as Health Visitors. Though the Health Visiting functions of such workers are fairly distinct, their relationships with clients and colleagues are also rather different from those of the full-time Health Visitor.

No objective study of the relative effectiveness of these varying types of workers has been made, and it would present great difficulties. Policy is determined by local opinion and experience.

286. A general improvement in the physical health of the population, and especially in the health of mothers and children, must necessarily affect the Health Visitor in her role as health educator. It would be claimed by some that the need for attention to the healthy has diminished. The work is affected in another way. Mothers with their children now have the opportunity for free consultation with a family doctor. It may be expected that doctors will be increasingly concerned with child welfare and that the Health Visitor will necessarily be associated with them.

287. Besides being a health educator, the Health Visitor has always obviously been faced with the necessity for giving social advice and taking social action to make effective the health education that is her primary concern. Dirt, squalor, neglect and illness can hardly be remedied by education only; the Health Visitor has always had to "pitch in" and find some way of helping clients to better material standards. The Health Visitor has always, however, been expected to carry a large case-load and much of her work is concerned with people not in social need. Except in times of crisis, it can be assumed that social action could only have been secondary to her main task. The war and the period of reconstruction have been times of great social change. Social welfare legislation has created or developed services which offer increasing opportunities of service to a variety of social workers. We can safely assume that the social aspects of Health Visitors' work have reflected the new situation. Our studies—limited as they were—suggest strongly that the purely social element in visiting for health purposes has increased and is larger than many suppose. It still does not, however, constitute more than an incidental aspect of the main purpose; Health Visitors go to their clients for health education purposes, not primarily to remedy social difficulties. Social welfare as a whole is highly complex and many branches of it call for expert knowledge. Even if this were not so, the shortage of Health Visitors, concentration on the purpose of health education and the great variety of problems thrown up by the Health Visitor's peculiarly extensive clientele would have prevented much more from being done. In the event, other and "non-medical" workers have been developed or created to do this work, which may arise both with families where there are mothers and children and with other families. These workers are usually specialised in the sense that they are concerned with one aspect of service or one relatively limited class of clientele in need, but they may be non-specialised in the sense that they may organise for their limited clientele a very wide range of services and facilities. They thus contrast with the Health Visitor, with her fairly narrow *main* purpose directed to a very wide and actively visited clientele not necessarily in obvious social or economic need.

288. The nature of the problems which face all concerned with medico-social problems seems also to be affected by marked improvements in material conditions. Problems overlaid while material improvement was of first urgency are now thrown into relief. The general raising of standards, for example, makes embarrassingly obvious the relatively few incompetent families whose chronic inability to achieve the minimum standards now set

by their neighbours has earned them the title of "problem families". These unfortunate families may well be, however, merely the most obvious sign of the social ill-health that many think is endemic in a modern industrial society. Physical and mental ill-health and cultural and social patterns are all involved and the part played by each factor cannot clearly be seen. There is no sign of a comprehensive diagnosis, to say nothing of a cure, and perhaps to hope for one is too optimistic. All that can be attempted, at present, is to deal with breakdown as it occurs and to seek to avoid breakdown by early observation and preventive action. Not only humanity but economy makes the attempt desirable. Much physical illness and maldevelopment can, for example, be prevented by timely advice and help; the social and economic effects of illness can be mitigated; the parents who cannot manage, the aged and handicapped who are losing their ability to manage, can be supported if helped in time. It is widely held that much mental illness has its roots in social conditions generally and especially in faulty relationships within the small socially isolated family unit. The emphasis naturally lies on family welfare in a wide sense, with the mother and growing children, as the most vulnerable group, in greatest need of protection. Both clinicians and sociologists clearly have their part to play.

289. If a comprehensive approach is as yet impossible, it is at least desirable that fragmentary approaches should be co-ordinated. The "problem family" attracts many social agencies and the need for a planned approach in this case is obvious and is heavily underlined in Government circulars. It is, however, only a special case of what may well happen to a lesser degree in less spectacular cases of need with equal possibilities of frustrated effort and of confusion for the family. There is a wide-spread demand for a more rational ordering of visitation of families for health and welfare purposes generally and it is often suggested that as much as possible should be done by an "all-purpose" visitor. The practical objections to any proposal for an omnicompetent visitor are, of course, insuperable. No single worker can command the range of knowledge and ability required to observe, diagnose and provide a remedy for all medical and social problems of families in modern conditions. There may well be possibilities, however, in a limited approach. Much might be done towards reducing the number of visitors to the home and co-ordinating family welfare, if one worker with a well recognised function useful to a wide range of families at risk could act as a "common factor" in various medical and social teams that are dealing with a part of the total social problem. Such a worker could act as a "case finder" and rapporteur, given sufficient knowledge to recognise and describe the situation that calls for the services of other experts and to co-operate with and support their work. The Health Visitor naturally needs to be considered in this connection since she might fulfil a number of the requirements.

290. A wide variety of opinions about the future of Health Visiting have been expressed to us. It is fair to say that those with a medical background and those with a social science background have been in opposite camps. There is some common ground between them however. It is fairly generally agreed that the field work of Health Visitors should be among families where there are mothers with young children and that their main function should still be health education. This should be concerned with not only physical but also mental hygiene and should take account of family circum-

stances as a whole, so far as they can be ascertained. Equally it is agreed that health education should or could extend to such classes as the school-child, the tuberculous, the aged and chronic sick. In carrying out a health education function the Health Visitor would overlap other workers only in the sense that she was concerned with the same families. Disagreement begins with consideration of the social aspects of her work. Witnesses whose background was medical in character were advocates of the Health Visitor as a general family social worker. They thought she had special advantages because of her "health" background, since there were health aspects to so many cases and because of her wide field of visiting for a generally acceptable purpose. Witnesses from the social science group were inclined to accept the possibility of a general family visitor (while pointing out the practical difficulties), but they doubted for a number of reasons whether the Health Visitor was suitable for the role or whether it was wise to distract her from her valuable task of health education by making her more of a social worker. Wide as it was, her field of visiting for her present purposes covered only perhaps one quarter of all families at any one time; to cover more she must give up some work. The general family visitor would, they thought, need a social worker's training not less intensive than social workers received—much longer than the Health Visitor's own public health course. Case-work functions were beyond the competence of those without proper preparation for them. They were too time-consuming to be shared with other functions and required an entirely different approach and work load from that of a routine visitor.

291. We shall have these views in mind in considering the field in which Health Visitors should work in future and what limitations must, of practical necessity, be put on that field. We should, however, also consider what additional functions may be added, to take the fullest advantage of a wide range of visiting. Even now the Health Visitor is in no sense an exclusive visitor. Many other workers, notably the general practitioner, have a close interest in the same subjects. As we have noted elsewhere, moreover, another Working Party(1) has already begun to consider the role and the training of social workers in much the same field that the Health Visitor will occupy. We shall, therefore, find it necessary to consider her relationship with other workers, avoiding however rigid lines of demarcation which seem singularly inappropriate to family welfare. We shall need to review in general terms the training required leaving it to the appropriate training body, however, to work out details that may well need to be constantly reviewed to meet changing circumstances. We have noted that many think the training and experience required as a whole is unbalanced and the public health part of it too short, too formal and too cramped. We shall need to look at conditions of service generally.

292. Recruitment, training and field of work, are, however, interdependent. We shall bear in mind, throughout our recommendations about the Health Visitor's work, the numbers of staff of a given quality that might be attracted by reasonably good conditions of service to the profession and the kind of training that could suitably be given to them.

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(1) Younghusband Committee.

CHAPTER X

THE FIELD OF WORK AND FUNCTIONS OF HEALTH VISITORS

293. One of the dangers facing Health Visiting is its very utility. Health Visitors are "willing horses" and it is clear to us that some of them are set to a remarkable variety of tasks. There is an obvious risk of overloading, of creating jacks-of-all-trades who are masters of none. Field of work and function must be considered together; if the field is too wide or the functions too diverse and demanding, the future Health Visitor will be ineffective. We have referred to her as health educator and social adviser and we think that whatever the field, health education and social advice should be her principal functions; any additional work should be incidental to these. Both these terms are wide and in need of some clarification. Both are functions in the most general sense common to all workers concerned with patients and other clients and their families. They are closely interrelated. Health education by Health Visitors we shall consider primarily as practical advice to members of families in their homes (and elsewhere) on their personal health, including demonstrations of methods of carrying out the advice. Secondarily, for those with special aptitude, we should think of health education as including the use of a wide range of media for teaching sound principles to a wider public or in schools. "Social advice" includes any social action taken to enable the client to follow the health advice given—usually direct practical advice on family management but often advice to turn to others when more help is needed. It must also include, however, advice on matters brought to notice that have superficially little or no bearing on the immediate question of personal and environmental health. It would be clearly wrong that an obvious difficulty should be ignored merely because the visitor was not directly concerned. On the other hand social action is, in general, limited to advice to the client, referral of the case to another worker or a recommendation that a service should be provided. Two general conditions attach to these functions. Although the visitor is concerned primarily with an individual, it is clearly right that she should take into account all the facts available to her that affect the nature of the advice given. She must, therefore, take account of the unit—the family—of which the individual forms a part, and not only of physical but of psychological and social factors. Secondly, her activities must be limited by the necessary functions of others (who will have equal respect for hers). At present the Health Visitor is exercising these functions mainly in relation to mothers and young children, schoolchildren and the tuberculous. It is for consideration in the first place whether it is desirable that she should continue to do so to the same extent.

Mothers and Young Children

294. There has been a dramatic decline in the maternal and child mortality rates in recent years. Many factors have contributed to this but Health Visitors have played a notable part in the work not only directly with the present-day mothers but indirectly through the influence of by-gone Health

Visitors on the mothers of earlier days. To some it seems questionable whether the Health Visitor has still so important a part to play. The battle, they would claim, is already more than half won and it is doubtful whether health education alone can have much further effect or whether the social advice directly associated with it is needed by so many. In any case, they would add, other forms of education now exist; influential features appear in the Press and weekly periodicals, on the cinema screen and on the radio from which mothers can get good advice. It would be well, on this view, to redeploy Health Visitors on more urgent tasks or concentrate them on cases of greatest need. Recent official circulars urge concentration on the prevention of breakdown in potential problem families.

295. There is force in the arguments for redeployment, but there are other considerations. Maternal and infant mortality can be regarded as low only in relation to its black history—there is room for much improvement. There are still areas with figures well above the average. The problems of still-births and neo-natal infant deaths are still obscure. That there is much scope for work on child morbidity is well illustrated by the survey of a thousand families in Newcastle based on the observations of Health Visitors(1). In any case, it cannot too lightly be concluded that advances in education will be maintained unless they are supported. Each new generation of mothers in its turn needs practical advice and demonstration and the emphasis of advice changes with changes in social conditions and advances in knowledge. It certainly cannot be assumed that popular health education in periodicals and elsewhere is the sole answer. These are indeed an adjunct to personal teaching —Health Visitors would do well carefully to study what their clients read— but they can at best deal in generalities and they cannot be a substitute for on-the-spot demonstration. There is some evidence that those who take the most intelligent interest demand the most help and explanation from the Health Visitor. On the other hand the too literal reader, taking such material at its face value without expert interpretation, may suffer needless anxiety. To turn to the hard case—the " problem family "—it will not necessarily be the Health Visitor who holds the key to rehabilitation. Breakdown may result from many causes, though no doubt poverty and mental subnormality may be frequent factors. The potential breakdown is still harder to define or to isolate and therefore to prevent. While prevention is better than cure, it depends for its success on complete observation of the field of risk; if the scope of observation is reduced, opportunities may be lost. Moreover, the same general improvements in material conditions which are the basis of the argument for redeployment have uncovered new risks of mental ill-health and a need to promote mental hygiene. Of the Health Visitor's part in this we shall have more to say. If it is true, however, that much maladjustment in childhood and mental illness in later life are due to faulty social and family relationships, especially affecting mother and child, and if these disorders may occur indiscriminately among all classes (as they are said to do), there must be serious objections to a reduction in the visiting of families with mothers and children. These families may be not only the most vulnerable group but the most rewarding field of preventive work.

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(1) Spence, J. *et al* (1954) " A Thousand Families in Newcastle upon Tyne : an approach to the Study of Health and Illness in Children ". Oxford University Press.

296. It is clear from our figures of visiting that Health Visitors now visit the greater part of families with children at least once. They naturally adjust their frequency of visiting to need and to the possibilities of clinic contacts. If, however, the present numbers of staff were to be concentrated to any great degree on a smaller field, many families could not be visited at all. Clinic consultations could, of course, save staff-time by making selective visiting easier and safer. But satisfactory conditions do not often exist in clinics, that is, facilities for consultation in absolute privacy and the certainty that a mother will meet the particular Heath Visitor in whom she has confidence. It would indeed be a remarkable Health Visitor who could claim, on the basis of two or three short visits to the mother, that she had established a relationship such that she could rely on the mother seeking her advice, or that she could assess the whole family situation and predict its course, with any certainty, in the next two or three years. Material conditions at the initial visits could hardly be a sound guide. Continuity of contact must surely be maintained. The redeployment to other duties of staff engaged on maternity and child welfare work entails the risk that families in need of help may not receive it. The aim should be to offer as full a service as possible to families where there are young children. Even when there is a shortage of staff, however, it should be possible also to extend the range of service of Health Visitors to deal with other problems of importance. The proper direction of existing staff, discontinuation of inessential duties and vigorous local recruitment policies are essential.

School Children

297. Although a large number of parents attend when their children are medically examined and on other occasions and can then consult the doctor and Health Visitor, we think a closer link with the home will often be as essential to the care of school-children as to the care of mothers and children. The home visit is the essential link and the qualified Health Visitor the right person to make it ; in most areas that link is weak and should be strengthened. Whether at the home or at the school the essential work of Health Visitors, on which all their training turns, is health education and social advice. It is wasteful to employ them on duties that could as well be done by nurses who have not the additional qualification as Health Visitors or even by non-nurses. Expenditure on the employment of more nurses or lay staff in order to release qualified Health Visitors for work that wholly employs their skill would be money well spent. It may well be true that in some areas what is wanted at the present time is not more qualified Health Visitors but more staff with lesser qualifications. Official policy strongly discourages the under-employment of Health Visitors and most of our witnesses have endorsed the official view. Yet it is apparent that Health Visitors are frequently employed on work that offers little or no opportunity for either health education or social advice and that others could do as well. The respective duties of nurses and Health Visitors must be reviewed to enable the latter to concentrate on work proper to them. In relation to any activity, the test should be : is there a sufficient opportunity for health education and social advice to justify the attendance of a qualified Health Visitor? If this criterion is not met, employing authorities should review their arrangements. It might be useful to employ the term " Health Visitor " only in relation to staff who are carrying out duties requiring the Health Visiting qualification and to

reserve the term "school nurse" (now commonly applied to all nurses in the School Health Service) for those who carry out duties calling only for the nursing qualification.

298. We should agree that Health Visitors should be employed in connection with medical examinations where the opportunity is presented to carry out health education among parents and to discuss cases with doctors and teachers. Health Visitors should also be responsible for "nurses' surveys", as recommended by the Ministry of Education. Visits to schools to discuss with teachers and head teachers general or specific education and health problems arising from defects discovered in children; follow up of cases with the general practitioner or hospital; or active membership of parent-teacher associations are also important tasks calling for a Health Visitor's special skill. We should not think it necessary for a Health Visitor to attend minor ailment clinics, cleanliness inspections (or cleansing) or the majority of specialist clinics. Health Visitors attending sessions where their proper skills are needed should not also be asked to carry out such duties as routine weighing and measuring, sight testing or work which can without difficulty be done by others. It has been argued that dividing the work functionally would often mean that Health Visitors would be acting on information supplied by others instead of their own direct observation of the child. We cannot accept that it is necessary for the Health Visitor herself always to have found what is wrong in order to follow it up. As in many other fields, she is perfectly capable of acting on good reports; in any case of doubt she can always see the child herself. Others argue that it is uneconomic to employ two workers when the more highly skilled of the two could do the work of both; since Health Visitors are also nurses they might as well do any work that calls for nursing knowledge. Such a view could only be justified if—as may happen in rural areas for example—the attendance of the Health Visitor is essential for the whole of a particular session, although she may not be occupied for all the time on her own work. In the long run there is no true economy in putting skilled hands to unskilled work.

299. Health Visitors could in fact be employed in other activities where their skills as health educators and social advisers could certainly be used to great advantage. More and more attention is being given to children whose education and well being are affected by emotional or behaviour difficulties. The child guidance service has been developing rapidly but it is in need of staff who can supply good information about the home and the family and on the other hand can help to support the family and interpret the work of the experts to them. This is skilled work in which the Health Visitor is well placed to help and in which, given suitable training, she could render valuable service. Some indication of her potential value in this kind of work is given in a report on the part played by the equivalent of the Health Visitor in the mental hygiene service for school children in Vancouver(1); we have also taken note of experimental developments in mental hygiene work in the maternity and child welfare service of the London County Council and elsewhere. The Committee on Maladjusted Children(2) has in fact recommended the employment of Health Visitors in the child guidance field. We are glad to endorse their views.

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(1) Maclennan, J. M. and Small, M. E. (1955) "The Work of a Mental-Hygiene Division in a Public Health Department." Lancet, i, 142.

(2) Report of the Committee on Maladjusted Children (1955), Chapter XVI. H.M.S.O.

We should expect that Health Visitors might similarly take a fuller part in work with children suffering from other handicaps. We should look for a better co-ordinated approach to families and fuller use of the opportunities the Health Visitor has to do supportive work and gain relevant information in the course of her duties.

We should also look for expansion in another part of the field, namely, "group education". This would deal with much the same content as the advice given to parents and children but it would approach closer to the everyday work of teachers, who should themselves make the main contribution. On such subjects as mothercraft and parentcraft for adolescents, Health Visitors will often be able to make an approach to pupils based on more comprehensive knowledge than can teaching staff. Health Visitor's talks on mothercraft are included in the school curriculum in a number of areas. The practice is to be commended, but success depends on the availability of staff with a gift for this kind of work. Consultation between teaching, medical and Health Visiting staff will be desirable, whatever arrangements are made. Health education in schools on any subject will be most effective where such consultation takes place.

300. We endorse, as most authorities have done, the official policy of combining the Health Visiting services of the local health and education authorities. If it were necessary for the Health Visitor to undertake *all* duties in the School Health Service, regardless of the skill required, or, if as has been suggested to us, the School Health Service were an exclusive service where the vast majority of contacts should be in schools and clinics, then indeed there would be something to be said for an exclusive Health Visiting service specialising on school health work only. We do not believe that either of these contentions is justifiable. There must in fact be close contact between the services. No arrangements for liaison, conferences and exchange of records can be so satisfactory, however, as the employment of the same Health Visitor for both school and child welfare work. Where the work is not combined in this way there would be an unnecessary hiatus in the long established Health Visitor-parent relationship when the child goes to school. The schools would lose the value of that relationship and would have to build anew. The Health Visitor would lose the chance to help during an often difficult period of transition. The local health service would lose its contact with a family perhaps for years and also would have to re-establish itself when again needed—after all there is at least a possibility that families in need of support once may need it later. Where there are children under school age and school-children in the same household there would certainly be unnecessary overlapping of visits by workers with identical functions.

301. It has been represented to us that different forms of organisation are forced on local health and local education authority services by geographical factors. It is easy to visualise a situation where a secondary school might draw pupils from an area so wide that contact between the school and all the area Health Visitors concerned might be exceedingly difficult. Where there is a shift of population to a new housing estate which is not directly served by a school there would also be difficulty. But staff working only in the School Health Service would be equally handicapped; they could hardly establish contact with homes so far-flung (and in practice it seems they do not). In the ideal situation, the Health Visitor responsible

for the area in which there is a school would act as school Health Visitor for that school. The pupils living beyond her area could be covered by the Health Visitors for the home area. We see no reason why the ideal should not generally be realised.

New Possibilities of Service

302. Our recommendations so far have been to the effect that the care of the mother, young children and school-children should continue to be the major pre-occupation of the Health Visitor. In this work she needs to take full account of the physical, social and psychological factors in the family situation that affect the quality of her advice, so far as she can ascertain them. She may thus be confronted with a wide range of problems, some of which are now dealt with by general duties staff, some by specialists and some hardly at all by any worker. We have next to consider whether and to what extent general duty Health Visitors should give more attention to such problems bearing in mind that the need for service will arise not only in families with children—with whom the Health Visitor has a natural rapport—but also in other families and households. To some extent we shall be shooting in the dark for little enough has been established about the precise needs of clients and possible clients, and the direction and nature of changes in demand and the best ways of meeting them depend on factors that cannot clearly be seen. We shall essentially be examining possibilities that are already apparent within the National Health Service and School Health Service but are not yet fully realised, that demand both a medical and a social approach and that are within the power of comprehension and practical usefulness of one worker. We shall assume in assessing the Health Visitor's part that her primary functions as in all her work are health education and social advice.

Care and After Care

303. The striking thing about Health Visitors' work is that it is concerned largely with people who are well or at least not obviously ill. Their visits are paid on normal occasions. Naturally they are confronted with illness but responsibility for care has usually rested with others—the doctor and the nurse. About one-tenth of Health Visiting work, is however, concerned with communicable diseases. Except when epidemics of infectious diseases occur, the Health Visitor's most important continuing responsibility in this regard is tuberculosis. Her work with the tuberculous well illustrates the nature of this aspect of her duties. Here, the Health Visitor visits homes, not because there are children but specifically because there is an illness. She is concerned with health education; she explains to the patient the implications of his illness and the chest physician's advice; she explains and demonstrates to the family how the illness must be managed; she encourages and gives re-assurance. She is deeply concerned with the social consequences; she traces contacts; she reports from time to time to the chest physician on the conditions in which the patient is living or on the facilities available for his care on discharge from hospital; she recommends, for example, the issue of equipment, the services of a home help, a priority for rehousing, financial help or help in kind; she helps in arrangements for convalescence and for rehabilitation. She needs perhaps more knowledge of and contact with the social agencies available to help and ability to co-operate with

them, and sufficient knowledge of the nature of the disease and its management to enable her to act with confidence as liaison between the chest physician, the patient at home and the general practitioner. No great modification in training would be necessary to enable the general duties Health Visitor to do the work that is appropriate to her in this field. In England and Wales the Regulations(1) governing the qualifications of staff would permit a State Registered Nurse to act as a tuberculosis visitor after a bare three months' experience at a chest clinic. Many existing tuberculosis visitors no doubt have better qualifications. It seems to us, however, that the social and epidemiological aspects of the illness, are of at least equal significance to the purely clinical aspects. Added importance will attach to the former as more effective treatments become available and the use of prophylactics such as B.C.G. develops. It is likely that the emphasis will tend to fall more and more on health education and the tracing of sources of infection and re-infection in the general population. Such work certainly calls for staff with a wide background of public health and social knowledge. We consider that the qualities of a trained Health Visitor will be needed. We recommend not only that this work should be regarded as within her field but that any measures taken to restrict Health Visiting practice to qualified staff should apply equally in future to tuberculosis.

304. What gives tuberculosis its urgent social importance is its continuing infectivity and the long period of invalidity and rehabilitation associated with it, entailing often severe psychological and social stresses in many cases. It is reasonable to suppose, however, that any long-term hospitalisation or disabling illness may present features calling for services differing only in degree from those offered to the tuberculous. As an illustration of the probable need for service we may quote a recent survey in Glasgow(2).

Cardiff, among other authorities, has developed arrangements for the follow-up of cardiac and gastric disorders and diabetes where a strict regimen needs to be supervised and home life may need re-ordering to suit the patient's needs. In a number of areas, arrangements have been made for the supervision of children or mothers before and after discharge from hospital to ensure that suitable home-care is given. We think it highly probable that the current practice of early ambulation and discharge may often create family problems that a Health Visitor could relieve, if she had the information in time. What is needed is a satisfactory arrangement with the hospitals —especially for timely information to reach the general practitioner and the Health Visitor. These two might naturally come to form the nucleus of a team which, reinforced where necessary by special services, could do much to improve the quality of hospital after-care and extend its scope. But there is we think, ample scope for such team-work within general practice itself. Indeed it might prove to be the vital factor in uniting and improving the domiciliary preventive and curative services.

305. The introduction of a family doctor service by the National Health Service Acts has in fact altered the whole outlook for the preventive services concerned with personal health. Expectant mothers and mothers with children of all ages may now have free from the general practitioner the

(1) S.I. 1948 No. 1415.
(2) Ferguson, T. and MacPhail, A. N. (1954) "Hospital and Community." Oxford University Press.

medical advice that they could in the past generally expect only from the local authority services. There is now no financial deterrent to any patient seeking timely advice from the family doctor about his or her health. This is especially true of women and children and of the aged of both sexes. It would be idle to pretend that the fullest advantage is yet taken of the situation. Not all doctors have time to undertake preventive work with all types of patients. Not all families have one doctor for the whole family. In many areas, it is customary or more convenient for mothers to go to the local authority clinic rather than to their own doctor and some may have more confidence in one or the other. The local authority has the advantage of having domiciliary advisory services that the family doctor working by himself must provide by visiting himself.

306. General Practitioners are becoming more and more conscious of the social aspects of illness, which add to the burden but increase the interest of general practice. Many doctors say they have experienced an increase in the volume of their work since 1948, arising in large measure from demands for re-assurance, preventive advice and the problems of home care. In a number of ways the trend is towards a more comprehensive service to deal with changing demands. There has been, for example, a marked increase in the formation of partnerships and group practices, with all their mutual advantages. There is, moreover, already a trend towards linking up local health and general medical services. Many practitioners either take part in local authority services or use local facilities for their maternity and child care work at clinics or health centres or in their own surgeries. They increasingly take advantage of the domiciliary services offered by the local health authority to meet the needs of their patients. General practitioners have the unique advantage of acceptability to and the respect of the vast majority of the population, who are willing to consult them and accept their advice as impartial experts on all manner of matters apart from purely clinical questions. It is not difficult to foresee a time when, with full co-operation between the medical officer of health and general practitioner, both curative and preventive services for the family at home will become an integral part of general practice. This appears to be the ultimate object both of the medical profession and of official policy. While the pace, the method and the direction of change will vary greatly with local conditions, the advantages of such arrangements to the family would be great and we should strongly endorse measures that would facilitate them.

307. The Minister of Health in his speech in 1954 to the County Councils Association referred to family doctors as the future "clinical leaders of the domiciliary health team". In such a role they would certainly wish to have among the team a worker who could both support their clinical work and help to advise them on the social aspects of their patient's problems. Health Visitors, suitable trained, could do much to meet such needs, hospital after-care representing probably only a fraction of their possible value. Such help would relieve some of the extra burden that attention to social and psychological factors must add to the doctors' work. In a later Chapter we shall deal with the way in which general practice and Health Visiting might be brought into association to their mutual advantage. It is sufficient here to point out that Health Visitors already on average visit between one-quarter and two-fifths of the families in a doctor's practice including in

particular those where there are especially vulnerable patients, mothers and children, to meet whose special needs the Health Visitor is at present primarily trained. Experience in some areas already shows that the Health Visitor may, if she has the practitioners' backing, extend her usefulness without great difficulty to patients who are bed-fast or who suffer from chronic illnesses of a less disabling order. The aged sick are a great anxiety to many doctors. In many such cases oversight by a worker who has a good health background and can mobilise services, such as the invaluable home helps, or the assistance of voluntary bodies, may be all that is necessary to stave off the need for admission to hospital. We see no reason to doubt that the Health Visitor's services could be usefully employed by the doctor in any case where health education and practical social advice were desirable.

Mental Hygiene and Mental After-Care

308. One of the most serious problems facing the health services is the problem of mental illness. There is no conclusive evidence that its incidence is increasing, but a more enlightened attitude on the part of the public, a wider knowledge of the nature of mental illness and the possibilities of curing or relieving it have created demands for treatment that cannot be met by the existing hospitals and their staffs. Treatment cannot always be given early enough and there is the constant danger that wards will silt up with apparently irrecoverable cases. There is a real need to relieve the mental hospitals, which already account for two-fifths of the occupied beds in the hospital service. A similar situation exists with regard to mental deficiency.

There is no clear picture of the extent of mental illness in milder forms not needing in-patient care. It seems likely, however, that the more severe disorders represent only the visible peak of a largely invisible iceberg of mental ill-health. A close connection between mental and physical states in certain illnesses has been established in some cases and is suspected in others. Every serious illness carries with it its burden of anxiety and the strain that this places on relationships within the family may be disabling in itself. The neurotic are said to be among the general practitioners' constant visitors.

309. Little is known for certain about the aetiology of mental illness which would enable definite preventive action to be taken. It is widely held that the early relationships of mother and child and the way in which the child's development is guided may have important if not decisive significance in later childhood, adolescence and even adult life. If there is serious distortion of relationships in early life, maladjustment and pre-disposition to neurosis or psychosis, it is said, may result. Family relationships generally, we have been told, may have their influence, mainly perhaps, but not only, while the children are growing up. Some think that modern society, in which family groups tend to be small, socially isolated, mobile and lacking roots in any neighbourhood, itself creates conditions favourable to illness. If they are right the risk exists wherever such conditions of instability exist—in the suburb at least as much as in the slum. Since causes are so indeterminate, great caution is necessary in suggesting any road to a remedy. What we may regard as certain, however, is that there will for many years be hardly enough expert medical, nursing and medico-social workers to deal with the problem of cure when breakdown occurs, to say nothing of making a comprehensive

attack on the problem of prevention. If anything is to be done in the way of prevention it must be done by the " inexpert ", with such help and guidance as the expert can give. Clearly there is a need for the widest possible field of observation and equally clearly no possibility—if it were even desirable—of recruiting a new corps of " mental hygienists " for observation purposes. In fact, the general practitioner and the Health Visitor, especially if they work in one team, are well placed for this work, as they are able between them to observe almost all families in the country, as an incidental to services which are invaluable in themselves.

310. Health Visitors, we gather from the widespread demand for training for the purpose, recognise that this is a field that most of them have not yet fully explored but that they are eager to enter. Their part, as we see it, would be unspectacular though invaluable as preventive work usually is. The work is necessarily exceedingly difficult because of its very uncertainties and the pitfalls for the incautious must be many. First and foremost, we think the Health Visitor can make her contribution in the course of her work with mothers and children of all ages. She would need a broader basis of training including much more knowledge of the psychological factors in parent and child relationships and child development. She would also need the time and opportunity to gain the confidence of the parents and a real insight into the family at home. The Health Visitor could do much to steer the family clear of the more obvious difficulties. She could provide invaluable information to the general practitioner, or to the medical officer, the paediatrician or the psychiatrist at the child welfare clinic, or to the child guidance team. She could help to explain what her colleagues are aiming at and how to translate their advice into practical measures in the home. She would need to be wary of exceeding her powers. Quite apart from her maternity and child welfare work, however, she could bring the same techniques to bear on any social problem or problem of illness with which she is concerned—evaluating the psychological factors in the situation and in the advice she must give, explaining, re-assuring and sympathetically listening. Listening may be all that is necessary in a great many cases—what has been described as " psychiatric first aid ". Where signs of excessive departure from the normal in individual behaviour or relationships occur she would seek more skilled help and encourage her client, if necessary, to seek advice and follow it. This work might be described as reconnaissance and close support. Where illness is already apparent the care of the patient will usually be already in the hands of experts. Subject to their judgment and under their guidance the Health Visitor can help with selected cases. Usually we think these will be those where help and encouragement to patient and relatives or a periodic oversight is what is most needed and a certain stability has been reached. Much depends on individual personality and not all might be suitable for the work, but many Health Visitors could in this way be of direct help to hospitals in delaying the need for admission and facilitating trial periods at home or discharge of long-term patients to make early treatment of another case possible. We have ourselves discussed the working of an experiment on these lines at Newcastle[1]. On the other hand, expert help is by no means always available. Help cannot be denied on that account. The Health Visitor's training should enable her to approach the problem of mental care and after-care with understanding, for at times

[1] Chapter II, paragraph 118.

in some areas she will be the only person available for the work. If Health Visitors were to undertake more, they would need special training.

Mainly Social Questions

311. We have said that Health Visitors can particularly help the doctor in the care of the aged sick. Their role with the failing and aged who need no medical attention is more problematical. Certainly failing strength and energy may lead to failure of health, in its turn often the beginning of a social problem. If the Health Visitor is brought in at an early stage, her encouragement and advice on diet, hygiene and general care could be invaluable, particularly to the elderly living alone. Some of the official services affording practical help to the aged are outside the ambit of the health services. A considerable amount of the domiciliary work with the aged is likely to be done by voluntary bodies, such as old people's welfare committees. Much of the Health Visitor's work will therefore consist of co-operation with welfare organisations and the welfare department of the local authority. She should have a recognised place in schemes of official or unofficial help—called in wherever there is a health problem with which she can assist or herself calling for the help of the appropriate organisation when, as may often be the case, she is first on the scene. She will no doubt play a special part in the care of old people in households that she is visiting for other purposes.

312. Similar considerations apply to the handicapped adult as distinct from handicapped children (with whom we have recommended that the Health Visitor should be closely concerned). Health Visitors will inevitably meet with cases of disabling handicaps in adults in the course of their visits and some will come to their attention as needing after-care following hospital treatment. It is important that they should have sufficient knowledge of what is being done in the way of rehabilitation, placement and other welfare services to enable them to support this work.

313. What is said above should apply to mental defectives also. We are not convinced that there is any need to distinguish between defective and other children for these purposes. Health Visitors are among the first to ascertain the low-grade. The great majority of higher grades are ascertained at school, a process of which the Health Visitor working in the School Health Service should have knowledge at an early stage. Having contact already with the family, from the child's birth, she is well placed to help in the distressing period when the fact of defectiveness has to be faced and family life adjusted to it. She can equally well provide a service for the defective child at home as she does for other children. If the child goes to an occupation centre, she will still keep in touch, as she would do if the child were at school. She might well indeed continue to act in the same way as a "school Health Visitor" in relation to the older defectives at occupation centres. But, in cases of special difficulty and, as with other handicaps, in the case of adolescent and adult defectives, problems of a different order may well arise that call for the services of a specialist in this work.

A Family Visitor?

314. A number of points stand out from our recommendations. Firstly it is obvious that the Health Visitor will have the opportunity for making

contact with an extremely wide range of families. Already her work in the local health and education services may take her to perhaps two-fifths of all families and households and these will be mainly families with children, in some respects perhaps the most vulnerable group. The close association with general practitioners which we are confident will be developed will greatly add to the number of families within her field since she will be concerned also with families where there are no children. Probably in this way she may be in touch with the majority of families and households who are in need of help because there is some problem of physical or mental health. Secondly, she will be visiting for a recognised and useful purpose with the backing either of a statutory body or the family doctor. Thirdly, she will be concerned in every case with the affairs of a family and not merely with individuals. Fourthly she will inevitably be confronted with an even wider range of problems than at present, a much larger proportion of which will be " psycho-social " in character than hitherto, and will be brought into closer touch with a wider range of workers who specialise in such problems.

315. It would, of course, be foolish to suppose that the Health Visitor could be equally effective in all aspects of family welfare. We expect on the contrary that she will be really expert in only a few, mainly those where problems of health are dominant. It would be rash, too, to expect that all Health Visitors could adapt themselves to a wider role with equal ease. At the same time we are satisfied that the training of the Health Visitor could be so arranged that she would be better able to appreciate the problems that other workers face and the way in which they deal with them. She could thus be put into a position to observe the early signs of distress in fields in which she is not (and need not be) an expert, to consult with the appropriate worker and to help in any measures that may be arranged. Where no such advice was available she could assess what " first aid " measures she could herself safely apply. She would thus have the opportunity to share in the work of a variety of family health and welfare teams that without her might have no common membership. Her contribution would be to act as a common point of reference, a common source of information of a standard kind, a common adviser on health teaching—in a real sense, a " common factor " in family welfare. She could help to eliminate continual visiting of one family by a number of workers for purposes that are essentially the same, in particular by relieving others of the need for purely supportive visits. In many respects. therefore, it appears to us that she could satisfy the requirements for a general purpose family visitor that we outlined in Chapter IX.

316. If the Health Visitor is in fact to undertake that role a number of problems pose themselves. Firstly, do the tasks allotted to the Health Visitor call for greater knowledge and ability than can be found in the probable field of recruitment? In our view this will not be so. The functions of observer, rapporteur and co-ordinator (in the sense we have adopted) on which our conception of a family visitor is based would be subsidiary and incidental to the main purposes of health education and advice and should be within the grasp of a well trained Health Visitor. We should expect that the minimum standard of capacity demanded of recruits may have to be raised. Secondly, are the numbers likely to be forthcoming? We should agree that a considerable increase in the staff available would be necessary.

While re-organisation of the present work may yield some surplus of staff-time, further recruitment would, however, be necessary and might be difficult though not impracticable. Thirdly, it might be suggested that the family visitor of the type described in the preceding paragraph might more appropriately be recruited from persons without a "health" background. Looking at the services with which we are concerned, it seems to us that, over the field of families at risk, the problems confronting a general family visitor are more likely than not to be concerned with the prevention of ill-health or ill-health itself. If we are right, it seems obvious that a visitor with both a "medical" and a "social" background would have the advantage. We should not, therefore, think it desirable to expect workers without that type of experience to undertake the work. Health Visiting already represents the largest homogeneous body of home visitors (except, of course, the family doctor). Full use has not yet been made of Health Visitors' capabilities or of the advantages of the wide range of visiting and general acceptability that they possess. We consider that the better course must clearly be to augment and improve the Health Visiting force to carry out the family visiting work described, rather than to create an entirely new force for the purpose.

CHAPTER XI

THE STATUS OF HEALTH VISITORS AND THEIR RELATIONSHIPS WITH OTHERS

317. There must obviously be limitations on the scope of the work of Health Visitors. Since they will occupy such a vast field and have such wide-ranging functions, the limitations can most easily be described by setting out what we think might be the status and manner of working of the profession and the way in which we would expect it to co-operate with the other professions with which the Health Visitor would be concerned.

Status of the Health Visiting Service

318. The professional status of Health Visiting will be determined in the long run by Health Visitors themselves. We need, however, to take note of certain features. Whatever the form of training may be and however much the Health Visitor may be concerned with the sick and those who care for them, Health Visiting is not sick nursing and the Health Visitor will not be responsible for the care and treatment of ailments and disabilities in the sense that home and hospital nurses are. Her relationships with others are accordingly unlike those of most nurses. Unlike them she will not as a rule receive precise medical instructions on how she is to deal with her cases ; she will accept the clinical judgment of the doctor in charge of a case but it will be for her to decide how to adapt and time her health education to meet his clinical requirements and to recommend what social action may

be desirable. On the other hand, although the Health Visitor's work will tend more and more to be concerned with non-medical matters, she cannot be regarded purely as a social worker. Unlike the majority of social workers she will not be primarily concerned with social manifestations; her clinical training will make her a valuable clinical observer and on some matters an adviser, able to provide information on physical, social or psychological matters, on which clinical judgments can be confidently based. She will be truly a medico-social worker in a broad sense of the term—playing a full part in both preventive medicine and social action. The Health Visiting service makes a distinct contribution to the health and welfare services, neither medical nor social but a composite of both. In future, though Health Visiting will still be much concerned with maternity and child welfare, it will also to a greater degree be concerned with other classes of clients and will be co-operating more closely with other services for which those immediately concerned with maternity and child welfare services, for example, have no responsibility. It follows that the Health Visiting service needs separate consideration in the administration of the health services. Responsibility for the service should rest with an experienced member of the profession who is conversant wth its current problems. Usually this will be the Superintendent Health Visitor though in some areas it has been found advantageous to appoint a Chief Nursing Officer who co-ordinates Health Visiting with home nursing and midwifery. Health Visitors should be answerable to their own professional head and she in turn to the Medical Officer of Health and Principal School Medical Officer as the administrative head of the department.

The General Duties Health Visitor

319. We think of a Health Visitor as a qualified professional worker exercising her talents over the whole range of her profession. It is important that so far as possible the range of the work should be well recognised so that the Health Visitor can know wherever she takes a post that she will have a worthwhile job with recognised scope and status on the lines of our recommendations. Some local variation will be unavoidable but the present confusion can only add to the difficulty of recruitment. In order to carry out effectively the whole range of work the Health Visitor will need to have personal knowledge of all the agencies providing services in her area and will inevitably find a substantial part of her time engaged in consultation with others. Her main value to others will often be the detailed knowledge she has of a wide range of families in need. If she is successful in gaining the respect and confidence of her families, she will become one of the confidantes to whom they naturally turn in difficulty as they turn, selectively, to the family doctor, the clergy and others. If she is to have time to get to know her families well and to be known by them, her radius of action must not be too large. A small reduction in the average length of journey, we have seen, will greatly affect the time available for visiting; if necessary, adequate transport must be provided. All these considerations suggest strongly that the Health Visitor's work should be organised on an area basis, her parish being large enough to provide a volume of work yielding full professional satisfaction yet small enough to make intimate knowledge possible. Ideally it should coincide with the area of operations of other workers concerned with the same families. Good relationships do not grow overnight and the

Health Visitor should be encouraged to remain in her area long enough for them to develop. As an illustration, it would obviously be valuable if a Health Visitor could see into their school days children born when she first takes over. Breaks in continuity are obviously not desirable. We should not think it necessary for her to live in her area though we should disagree with those who claim that this would be an actual disadvantage.

320. We think it would be advantageous for two or more Health Visitors to work an area together as a team and this should be possible except in sparsely populated areas. Each would be responsible for her own case-load of families but the team would work together for the area as a whole. They would thus have the advantages of relatively easy reliefs so that the area had constant cover and of easy consultation on difficult cases. They would also avoid isolation from the rest of their fellows. They would provide families in the area with an alternative point of reference; where one Health Visitor had been unable to make effective contact a colleague might be more fortunate. It follows that the Health Visiting area will be a professional entity in contact with but largely independent of the divisional or central headquarters in its day to day work. Every effort should be made by the administration to supply the Health Visitor with all relevant information and to avoid where possible requesting information in return. Standard returns should be as simple as possible and related to standard records. The Health Visitor will be making her own records and reports and conducting her own correspondence. She needs time for this which ought not to be absorbed in administrative paper-work. While there might be a simple central register of families visited showing the main purpose of visits, to facilitate co-ordination, the place for records is in the area, where practical co-ordination will occur daily. The Health Visitor should have clerical help if possible but both in what she passes on to colleagues and receives from them she must have an eye to confidentiality. There must be no grounds for suspicion that privately disclosed information might reach unauthorised persons. This is equally of importance to clients and colleagues.

321. Health Visitors need to have a proper base in their area and such facilities as would enable them to remain there all day. Its location, telephone number and the hours at which each Health Visitor could be found there should be well known to all concerned, especially her clients. A telephone would be essential; without it, consultation and co-operation, particularly with the general practitioner and hospitals might become unnecessarily difficult and letter and report writing would become an intolerable burden. The base will normally be a clinic or centre of the maternity and child welfare service since these are often distributed fairly uniformly in relation to population density. In rural areas, a variety of arrangements will be necessary including for example the use by agreement of any treatment centres. Ideally, space for records and for genuinely private consultation should be provided. It is a criticism of many clinics that mothers have little opportunity for talking privately to either doctor or Health Visitor; yet if, to facilitate selective visiting, the clinic is to be in any degree a substitute for the home visit in "safe" cases, this is clearly essential. She should be free to use her office as the base for consultation on any subject and not merely for maternity and child welfare services. It would be of some advantage to hold evening sessions, especially when it was thus possible to

see parents together. The clinic base might well become more commonly a meeting place for many workers with interests in problems facing the local health and school health services, as it has already in a few places. We were attracted by the experiments in small-area case conferences contemplated in Bristol, to be attended by Health Visitors and representatives of other services. It would clearly be an advantage that the general practitioner should be brought in and we were able to see that this had been done with fair success at the " William Budd " Health Centre in Bristol. Arrangements of this kind must eventually ease the Health Visitors' work even if they add to it temporarily. They might be no small contribution to the work of others with perhaps less favourable conditions for case conference work.

Organisation of Clinics

322. We have referred to the Health Visitor as based on a clinic centre and have outlined one way in which she might work there—that is, she would use the centre as her base, her office and her consulting room. It is convenient at this point to consider clinics in general terms, whether in the local health service or school health service. We think that one of the Health Visitors should be placed in general charge of the centre to ensure that proper arrangements for the sessions have been made. Ideally, the Health Visitor should be able to concentrate on health education both to groups and to individual mothers. Preferably she should be able to give her time to the mothers for whom she is personally responsible. The Health Visitor would naturally be available to the medical and other staff to give information and advice about the home and health educational matters. It would not be part of her normal duties to act as chaperon and surgery nurse. She would not undertake routine clerical duties and selling and accounting for food. These, like the tasks of setting up and clearing away, should be the work of ancillaries or volunteers or clinic nurses. There is probably considerable scope for the employment part-time of retired nurses and Health Visitors to do work of this kind. For example, many who have left on marriage might be willing to return to give part-time service. If, in the case of smaller clinics, it becomes a necessity for Health Visitors to undertake work that does not fully employ their skill, steps should be taken to reduce such work to a minimum.

Co-operation

323. Health Visitors should have discretion, within the general policy of the employing department, to decide on the need for and frequency of contact, reliance on clinic rather than home contact, the character and timing of visits and advice, referrals, recommendations and consultations in the course of their ordinary activities. In no field of work, however, can the Health Visitor regard herself as working entirely alone—a doctor, nurse, midwife, social worker may always be involved. The onus lies equally on all to ensure that all concerned are in touch. The Health Visitor has perhaps a special responsibility since she has such a wide field of families to cover. The essence of the matter is that there should be personal contact for discussion of common interests to achieve understanding and the mutual confidence that make future co-operation easy. The Health Visitor, therefore, needs to know personally the people in her area whose work will interact with hers.

Co-operation calls for a flexible and tolerant attitude. Agreement may not be easy and may involve compromise on matters even of apparently important principle. It may be necessary at times for the Health Visitor to undertake more than would normally fall to her or, on the other hand, to retire temporarily from the scene of action to leave full scope for another worker. She should be allowed full discretion to do this.

Health Visitors and Domiciliary Midwives

324. Midwives are statutorily required to perform certain services for expectant and nursing mothers, alone or in co-operation with a doctor. They have a statutory duty to visit during the lying-in period, defined as a period not less than 14 or more than 28 days after the birth. The majority of them are registered nurses, though a few still have only the midwifery qualification. Their training is in future(1) to include sufficient instruction in the care of the mother and child to enable them to undertake such care throughout the period of twenty-eight days after the birth. Practising midwives are required to undergo a refresher course every five years and on these occasions existing midwives will no doubt be brought up to date with the new syllabus. In relatively few areas as yet does the midwife's responsibility continue until the twenty-eighth day but it is the view of the Central Midwives Boards (and of the Royal College of Midwives) that this practice should become general. As more midwives benefit from the new training, it may be expected that their wish to exercise fuller responsibilities will grow stronger. We understand incidentally that there is at least no shortage of domiciliary midwives and none is foreseen—a situation unfortunately not true of Health Visiting, which, if it is to expand, needs to shed all work that can be done equally well by others.

325. The Health Visitor also is authorised by statute to give advice to expectant and nursing mothers when necessary. There is an apparent overlap of function with the midwife. The midwife rather than the Health Visitor does the bulk of the work for the mother during and immediately after pregnancy, including the practical arrangements for labour and lying-in. Only a minority of expectant mothers are visited at home by Health Visitors; not all of these do ante-natal work and the proportion of their time devoted to this work seems to be decreasing. It would be tempting to conclude that up to the twenty-eighth day the Health Visitor should undertake her health education and social advisory functions in the home only when called in by the midwife to meet recognised needs. There are, however, arguments against this conclusion, though we know that in at least one large city the arrangement is successful. With her special training, the Health Visitor is likely to be better able to assess social and psychological factors, both during pregnancy when sympathy and re-assurance are both so necessary and during the first month of the child's life, when the establishment of breast feeding, for example, may be hindered by factors other than the physical condition of mother and child. Both the Health Visitor and the midwife from their differing points of view should play their part with the general practitioner in the assessment of the necessity for admission to a maternity hospital where this question arises. The midwife who would be responsible,

(1) The Midwives Rules Approval Instrument, 1955. S.I. 1955 No. 120.

if the confinement were at home, would naturally need to satisfy herself about, and report on, the suitability of the premises and facilities available for the confinement. She should, however, consult the Health Visitor, who will often have considerable knowledge of the family circumstances. At ante-natal clinics Health Visitors should be responsible only for health education. The Health Visitor gains a considerable advantage from the earliest possible contact with the expectant mother, who at that stage will be more likely to be impressed with the value of her advice and, while an ante-natal visit may not be necessary in all cases, the Health Visitor should be free to call at any time. A true overlap will in any case only occur in the case of first children—where there are two or more children the Health Visitor will be going into the home in any event. In the post-natal period we see no reason to think that in the great majority of cases there will be any obstetric grounds for the midwife to visit after the fourteenth day. It is wiser that the specially trained worker—the Health Visitor—should take over not later than at that time. Transfer of responsibility, incidentally, should be the occasion for a discussion of the case and if possible a joint visit; a transfer of records is not enough. Hospital confinements create complications in the maternity services that we hope and believe can be eliminated. It is sufficient here to point out that when women leave hospital for home at or about the fourteenth day, there should be no reason for the domiciliary midwife to be concerned. The Health Visitor—who should have some contact with the maternity hospital—should be afforded the opportunity of taking over the case forthwith.

Home Nurses

326. Home nurses and Health Visitors have in the past very largely gone their separate ways. In future, the closer association of the Health Visitor with care and after-care will draw their paths much closer. The General Nursing Council's revised syllabuses will give future nurses a better insight into public health work and the national qualification for all home nurses that another Working Party[1] has recommended will reinforce the knowledge gained in basic training. With this preparation we expect that both workers will find little difficulty in working together, recognising that Health Visitors will not be practising nurses and home nurses will not be highly trained health educators and social advisers. Their common participation in the general practitioner's team will do much to eliminate possible causes of friction.

Combined Work

327. It will be recalled that we have defined the combined worker as one who undertakes home nursing or midwifery (or both) in addition to Health Visiting. The conception of combined duties is on the face of it immediately attractive, especially, for example, to general practitioners who find it necessary to work with nurses, midwives and Health Visitors, perhaps in relation to a single family. Problems of consultation, overlapping function and duplication of visits might obviously be reduced if the three jobs were done by the same worker. The situation is, however, confusing. Combined work in urban areas is carried out only in some of the smaller towns in Scotland and hardly at all in England and Wales. In the country areas, it accounts for a small proportion of the total time of Health Visitors in

[1] Report of the Working Party on the Training of District Nurses (1955) H.M.S.O.

England and Wales and an even smaller proportion of the total volume of nursing and midwifery. In the Scottish Counties, however, it is the prevailing practice. We are assured by some that in rural areas it is the only method that combines efficiency with economy of manpower for in such areas the population is scattered and authorities could not afford a more lavish staffing. There are rural areas, however, with scattered populations, poor communications and far from wealthy where full-time Health Visiting is the rule and is regarded as fully satisfactory. We are told that the demand for qualified combined workers is increasing; but the national statistics show a decided trend the other way over the years, especially in England and Wales, and we know of areas that have converted fairly recently to full-time Health Visiting. It is a fact that relatively few combined workers have the Health Visitors' certificate. Some say that criticism of such workers and of the system arises mainly from this; if all were qualified, all would be well. But it is a common experience of Counties in England, at least, that qualified staff willing to do combined work are exceedingly hard to attract. The suggestion that home nursing and Health Visiting alone should be combined has so far found favour to only a negligible extent. Opinions vary with experience pretty consistently. The main arguments advanced to us are set out in Chapter I([1]). They consist largely of assertions and counter assertions and we need only note that the "pros" are heavily outnumbered by the "antis" even in County areas taken as a whole.

328. What seem to us to be the most important factors are as follows:

(1) Health Visiting as we envisage it for the future involves the application of a wide range of health and social knowledge to a diversity of families in different conditions; it involves close collaboration with the general practitioner, the hospital and many social agencies and the exercise of careful judgment in the timing of visits and advice;

(2) in the view of most of us the work demands the services of a full-time highly trained worker if it is to be fully effective;

(3) in the foreseeable future we can see no prospect of combination becoming generally feasible, because there is no prospect of obtaining sufficient staff who have or are willing to obtain the necessary qualifications, and because the three-fold training for large numbers would be very expensive;

(4) combination is convenient and its disadvantages least marked in country areas including small towns;

(5) the home nurse-midwife even without the Health Visitors' certificate has for long served a number of areas to the evident satisfaction of her employers; a uniform national training for home nurses and the improved training for midwives will give future home nurse-midwives a better preparation to meet emergencies and render social first-aid; experience and their reputation with the families they serve may enable them to do excellent work.

329. We conclude that there are insufficient grounds for recommending that combined work should be regarded as a general principle of organisation or that the practice should be more widely extended than it now is. There

([1]) Paragraphs 54–56.

are on the other hand insufficient grounds for disturbing the existing arrangements in areas where they are well rooted and popular among not only the staff but also the public. We cannot, however, overlook the fact that qualified staff are so rare in these areas or accept that better home nurse-midwifery training or experience alone will enable unqualified staff to deal with the difficult questions for which even the Health Visitors' present training is thought by many witnesses to be insufficient. It is commonly held that in rural areas health and social problems are relatively few and mild and a lower standard of service can be tolerated. A recent survey of needs in country areas on behalf of the Carnegie Trust[1] suggests strongly that this view needs to be revised. The object of the survey was to demonstrate that unrecognised needs do exist, to tackle which qualified staff are needed. Medical and social welfare staffing in country areas is never likely to be so strong as in the towns and the expert help that the unqualified Health Visitor would need will often be lacking. Every effort must be made to arrange for existing combined workers to have the full training; where this is not possible, qualified Health Visitors must be engaged to give the necessary help.

Health Visitors and General Practice

330. The general practitioner already has a happy working relationship with nurses and midwives. It is their services that he will, perhaps, most often want and he will often consult with them direct. Knowing that the Health Visitor is a registered nurse with some midwifery training, he might well expect of her the same kind of relationship and, especially in emergency, the same kind of services that he receives from nurses and midwives. In fact, we must emphasise that such a relationship will not enable either doctor or Health Visitor to derive from their association the maximum benefit. We have suggested in paragraph 317 that the relationships of Health Visitors with doctors generally will differ from those of nurses with doctors in a number of ways. The relationship can be further illustrated by reference to the way in which consultants and almoners work together in hospitals, an analogy familiar to general practitioners. Like the almoner, the Health Visitor would be able to get in touch with all the available social agencies that could help the doctor's patient. In addition, she could in co-operation with the nurse and midwife greatly assist the doctor by visiting families on his list to explain what he wants done, to make it possible for his advice to be carried out and to report to him on the family situation. She can bring to his notice early signs of illness and thus help to avoid later breakdown. Where sympathy and friendly advice are needed, she can be the confidante of the family. She is likely to be most useful to the practitioner in his dealings with mothers and children, especially in infant feeding problems, with the tuberculous and with the chronic sick and aged, because her training and experience will specially fit her for this. There seems no reason why she should not be equally useful to him over the whole range of his practice.

331. If the Health Visitors' work is organised on the area basis suggested earlier in this Chapter, it should be much easier for the doctor to get in touch with the Health Visitor and unnecessary for him to have routine

(1) Lochhead, A. V. S., Editor (1953) "Family Casework and the Country Dweller". Family Welfare Association.

contacts with more than two or three Health Visitors. It will often not be possible to make Health Visitors' areas and doctors' practices coincide. One team of Health Visitors may well be working with a number of doctors, but the fact that areas of operation do not coincide should present no insuperable difficulties. The problem of scattered practices can be met by liaison arrangements which make the Health Visitor who is working with the doctor the channel of communication with distant areas. Such arrangements have worked well in Birmingham and may often be acceptable in other areas. The essential point is that personal contact should be possible when necessary, without delay and without inconvenience.

332. At present a working relationship is thoroughly established in only a few areas. The problem is how to forge the first link in the chain ; development seems to proceed unhindered when this is done. Certainly the first step is for the health department and local medical committee to secure that general practitioners are collectively and individually well-informed of the functions and training of Health Visitors and of the ways in which they can be helpful to the doctors and to agree on a positive policy of co-operation. Such a policy might well be based on the joint statement of principles by the British Medical Association and the Society of Medical Officers of Health(1). The actual starting point of service may well vary but work with mothers and children would be a favourable point of departure. This would represent a common area of interest in which both parties could at the outset recognise and respect the qualifications of the other. It is necessary that both should have a chance to meet and discuss mutual problems. In Birmingham and Bristol, the offer of generous facilities at local authority clinics gave the opportunity. In Birmingham, a series of social engagements afforded an opportunity for doctors to meet the Health Visitors who would work in their area. In Newcastle, a Health Visitor sends a card to the doctor after she has made a " first visit " telling him when and where she can be found. Elsewhere, Health Visitors have called on doctors at their surgeries. It has been not less important that the employing authority has been prepared during the necessary period of experimentation to accept the risk that visiting for other purposes might temporarily suffer. Once co-operation has been established the authority and the Health Visitor should do everything to foster it. Where a Health Visitor visits a family on the doctor's list for the first time, she should tell him. If she is embarrassed by demands for advice on a matter she knows the doctor has been dealing with, she should consult him as early as possible. If a doctor asks for a service at the head office the area Health Visitor should be told ; if she can, she should provide it and herself report to the doctor. The object should be to channel all the doctor's less urgent, complex or technical demands through her. What she cannot herself do, she will refer to colleagues. In all this, the crucial factor is the Health Visitor. If she succeeds she will have made a substantial contribution to family health and to the establishment of a family visiting service.

Health Visitors and Hospitals

333. The Health Visitor's position is perhaps at its most complex in the tangle of interests that surrounds the hospital services. She can, if she is

(1) Chapter I, paragraph 59.

closely associated with the general practitioners, play a useful part in simplifying matters provided suitable machinery can be developed for keeping all concerned in touch with events. The medical link between hospital and home lies in the relationship of consultant and general practitioner and it is important that there should be rapid communication between the two, to enable both to consider what will need to be done for the home-coming patient. At the hospital, the consultant will no doubt usually refer to the almoner's department patients who require her help. The general practitioner for his part will look to the Health Visitor to discover what help is needed and arrange what is possible. If the best service is to be given it is obvious that adequate liaison must exist between the almoner and the Health Visitor. The object should be, with the help of the ward sister, to pool the available social and clinical information so that necessary and available help can be provided for the in-patient's family or the patient on his discharge. If such liaison is to be effective there must be regular personal contact between Health Visitors, almoners and ward sisters. Hospital staffs, in particular, need to know where and how to get in touch directly with the Health Visitor who serves the area in which the patient lives. It may often happen, however, especially with large hospitals in big towns, that distances and the number of staff involved make it impracticable for all staff to be in regular direct contact on every case with which they deal. In such circumstances, arrangements similar to those we have suggested for the school health service might be made. The Health Visitors covering the area round the hospital might be made responsible for liaison between the hospital and other Health Visitors who may be concerned.

334. We have already expressed the view that tuberculosis work should be regarded in future as part of the duties of the general duties Health Visitor. The pattern recommended in this particular case might well prove to be acceptable in the Health Visitor's work with hospitals generally. Whatever special arrangements may be necessary in the earliest stages of illness, responsibility should be transferred to the area staff as quickly as possible. The Health Visitor's part in the work of the chest clinic, round which organisation of the work will no doubt continue to centre, should be strictly related to her Health Visiting functions. Responsibility for the organisation of the clinic should rest with the hospital, which should provide suitable nursing and ancillary staff for the purpose. If the Health Visitor is not present when a patient suspected of having tuberculosis is dealt with, she should be notified promptly so that she can visit the patient in his home and report to the chest physician on the circumstances of the case. She should attend when necessary at clinics with the patient to discuss the case with the doctor and receive from him full guidance on the clinical care of the patient on which to base her educational and social work. Responsibility for keeping the general practitioner informed rests, of course, primarily with the consultant but in her routine contacts the Health Visitor will keep the practitioner in touch with events. She will continue to visit the patient and his family for so long as the need for health education and advice remains. It will be necessary to a much greater extent than at present to keep the Health Visitor in touch with the work of the Care Committees and the Health Visiting service should be represented on them.

Health Visitors and Social Workers

335. In her role as "family visitor" the Health Visitor will find it necessary in a number of cases to take some form of social action arising out of her health education mission or incidentally to the visit. The proportion is likely, of course, to increase as a result of her association with the general practitioner. In many such cases, the provision of a service or introduction to a useful agency or to another worker may be all that is required. The help of the Health Visitor may be needed in assessing the true need of the family or the reason why they cannot comply with some requirement. It should be possible to call on the Health Visitor to assist as a practical educator in reducing or eliminating the need for assistance or in enabling the family to gain the full benefit from it. There seems to be a tendency for staff to be specially employed for this purpose when the Health Visitor, visiting the same family for different reasons, might as easily give or co-operate in giving the practical guidance needed. In our view whenever a need for general family welfare of this order is recognised, serious considerations should be given to the part that the Health Visitor can play, information she is likely to have and her links with other workers, to avoid the necessity for duplicated visits and the creation of new types of staff.

336. The Health Visitor may herself be able to deal satisfactorily by way of advice with many of the family welfare problems that she meets. In a substantial number of cases she will be handicapped by lack of time, however she arranges her work, or the problem may be beyond her ability to identify fully or deal with. Different techniques of approach, analysis and guidance may be needed to resolve it; a worker more detached from the life of the area may be desirable; clients themselves will as often as not choose some other person than the familiar figure of the Health Visitor. In such situations the social case-worker has special advantages of skill and tactical position. A clear description of this kind of situation in which differences of function appear was put to us in evidence(1). It will be one of the most important aspects of "family visiting" to recognise the situations in which there is a need for the services of a social case-worker, to approach the worker whose help is needed and to co-operate in situations where both are necessarily concerned at the same time. In return, she may expect herself to be consulted and informed of matters that concern her, where a social worker is helping one of the families with whom she is concerned without her prior knowledge. How this aspect of the work should be approached will obviously depend to a large extent on local circumstances, the type of problem and the kind of help available, and no clear-cut guidance can be given. It the Health Visitor is trained to look for such situations and is given an area to look after with full opportunity to know its people and social welfare resources, she should gain by experience the ability to select the case that needs referral and look for the right help. The position will no doubt be clarified from the point of view of the social case-worker by the Working Party on Social Workers already mentioned(2).

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(1) Chapter I, paragraphs 74–75.
(2) Younghusband Committee.

Specialisation in Health Visiting

337. The field of work that we have described is very wide indeed and the functions that have been suggested, though narrow in terms, imply an extensive range of knowledge and a keen appreciation of the possibilities of team work with many other types of worker. The Health Visitor's task will be of an even higher order than it now is and potentially of even greater social value. There must be a risk if the scope of a profession is made too wide that some aspects of it will receive insufficient attention by the general body of workers and specialisation on those aspects will become a necessity. That the danger is present even now is instanced by the situation in tuberculosis work in which field it is claimed that general duties staff deal with too few cases to become both expert and interested and can spend too little time on each case—partly also, however, because of over-insistence on routine visiting in other fields, under-emphasis on tuberculosis in training and shortage of staff. In some areas it may well be that for the immediate future tuberculosis will constitute such a risk that attention must be fully concentrated on it and specialisation may then be unavoidable. In some areas too there may be a case for the employment of specialists on particular subjects that call for special aptitude or extra training—such as major group education activities, liaison with mental hospitals or the supervision of persons with conditions requiring special help—for example diabetics. Generally, we should regard specialisation, however, as something of a danger because it would narrow the opportunities for service of the main body and reduce the attractiveness of the profession to first class people. There would be the risk that the specialist herself would in time lose touch with the main stream of professional thinking, to the detriment of both her clients and herself. Specialisation does little to relieve the burden on other staff who may still have to visit the same families for other purposes and it is extravagant of travelling time, for the area of operation of the specialist is naturally much larger. It must necessarily complicate the essential team work of family visiting. We think therefore that specialisation should be avoided or at least be kept within bounds. It should not be adopted unless it is clear that general duties staff cannot do the work. Some of the specialties that we examined during our visits, in relation to hospital after-care, for example, seemed to us to be properly within the scope of general duties. If specialisation is unavoidable it would be an advantage for the specialist to retain a small general duties area or return from time to time to general duties to keep more closely in touch with the trend of general development.

A Higher Grade of Field Worker

338. It is, of course, self-evident that the range of ability among Health Visitors is wide. A minimum standard may be set but a substantial proportion rise above this. Our own experience, supported by that of disinterested witnesses, is that a proportion of Health Visitors are potentially capable of advanced work of the first order. There are, however, insufficient opportunities at present for those with greater ability to assume corresponding responsibility —we have noted in Chapter IV the lack of attractive promotion prospects(1)—

(1) We do not regard the posts carrying small responsibility allowances as a sufficiently attractive promotion for these purposes.

and there is some evidence that a few Health Visitors who can ill be spared are seeking greater satisfaction in other work.

339. There will be, however, greater possibilities within the profession itself, as its scope grows larger. We should like to see recognised a senior grade, intermediate between the general duties staff and administrative appointments, with partly administrative but mainly field-work duties and covering the whole range of Health Visiting practice, that could utilise fully talent that is now under employed. Entry to the grade would be a form of merit-promotion and not merely the reward of seniority. Posts would be created not in a fixed ratio to the establishment but as and when they were justified by conditions. On the long-term we should hope that the grade could be reached comparatively early in the Health Visitor's career, though after a sufficient period of practical experience of general work, and should in course of time be a step towards administrative and teaching posts. An important—perhaps the most important—function of the grade would be to provide the general grade with professional support close at hand. The holder of such a post could thus help to keep work at the family level and avoid too much reference to headquarters by acting as adviser to a group of Health Visitors in difficult cases, especially those requiring referral to case-work specialists. The group adviser might herself accept cases referred by Health Visitors for more intensive work. She would be well placed to do this for she would carry little or no routine case-load, would normally be dealing with relatively few cases in any event, and would be sufficiently detached from a particular area to gain many of the advantages that the highly selective specialist claims, not without reason, to hold. While she would naturally give most of her attention to problems of particular urgency in her area she would not in any narrower sense become a specialist. One of her duties might well be the organisation of area-case-conferences and liaison with other professional groups. She would be helped in this if she were based on one of the larger or more central clinics where she could also be responsible for the co-ordination of health education. One of her more important tasks would be to organise the practical training of student Health Visitors and help to arrange for student nurses or medical students from neighbouring hospitals and others to gain first hand experience of the work of Health Visitors. She should have newly trained recruits under her tutelage until they were sufficiently well established in their areas. She would have an important part to play in spreading new ideas and principles among existing staff. This might be particularly important in improving their "mental hygiene approach" to their day to day work. We refer to the new grade as group advisers.

CHAPTER XII

THE TRAINING OF HEALTH VISITORS

340. The training of Health Visitors has always been taken in three parts—a hospital training, a maternity training and a public health course. Hospital training for most in the past and all in the present has meant training for registration as a sick children's nurse or, in the great majority of cases, as a general nurse; maternity training means Part I of the midwives' qualification

(and optionally the second part); and the public health element is essentially a post registration qualification. Each part has been prescribed hitherto by a separate training body, the nursing and maternity parts being designed for purposes that had little or nothing to do with the practice of Health Visiting and the final part taking account so far as possible of what had gone before. A better co-ordination of the trainings Health Visitors are required to undergo is obviously desirable, though clearly difficult unless special arrangements are made with the various bodies concerned. Any such arrangements would, however, at the outset, have to take account of the extent to which each of these elements would still be necessary and could be provided. In any case for a considerable period the piecemeal approach will continue to be necessary and we shall, therefore, first consider the future content of each element separately.

Maternity Training

341. The view has been expressed to us that Health Visitors could not carry out their functions under the National Health Service Acts or co-operate properly with the midwife without the full midwifery qualification. If Health Visitors intend to practise midwifery they must obviously become qualified. If they wish for personal reasons to qualify, there is nothing in the present arrangements to prevent them from doing this and then taking the Health Visitor training. We should hope that midwives would continue to be attracted to Health Visiting. We can see nothing, however, in the health education work of Health Visitors among mothers which would justify us in recommending that prospective Health Visitors should necessarily be required or even encouraged to qualify as midwives first.

342. We should agree with most of our witnesses that the first part of the midwifery training, which is taken exclusively in hospital, is not really a suitable preparation for Health Visiting. The courses usually omit domiciliary experience and are institutional in character. They are, moreover, mainly concerned with cases that in any event should not be confined at home. Student status is not yet general in midwifery training schools and much time we feel may be spent in them by prospective Health Visitors that could, for their purposes, be better spent elsewhere. A purely domiciliary training would not be satisfactory and in any event Part II of the midwifery certificate (which mainly deals with domiciliary work) cannot be separated from Part I. A combination of both hospital and domiciliary experience would be desirable but a telescoped version of both parts of the course is, we think, not likely to be approved by the Central Midwives Boards as a contribution towards qualification for the State certificate.

343. We think there would be wide support for a special maternity course for prospective Health Visitors designed not to qualify them to practise as midwives but to prepare them specifically for health education in the ante-natal and neo-natal periods and for co-operation with the doctor and midwife at these times. Such a special course would outline the nature of normal pregnancy, birth and post-natal periods and the work of the doctor, midwife, physiotherapist and others in the preparation of the mother for the birth, her care thereafter and the care of the newborn child. It would sketch the commonest kinds of abnormality and the measures needed to deal with

them. During the course the student should have the advantage of being present at births, both in the home and in the hospital and we are advised that this may be possible under midwifery legislation. Special attention should be paid to the effect of pregnancy and childbirth on the family. Emphasis should be laid on co-operation and the importance of proper arrangements for transfer of responsibility from midwife to Health Visitor without a break in continuity of care. The actual length of the course would be a matter for determination by the bodies responsible for training. We can see no reason, however, why students with full status as such should not normally get the knowledge and experience they need in a maximum of three months. The course would precede and be co-ordinated with the Health Visitor's training course but would be separate from it, since many future Health Visitor students would have a full midwifery qualification. No separate examination or record of training would be needed, since the object of the course would be solely to prepare students who were not midwives for the Health Visitor training.

344. The syllabus of the course should be prescribed by the bodies centrally responsible for Health Visitor training, with the advice and help of the Central Midwives Board as the principal authorities on midwifery training. The courses themselves should be the responsibility of the Health Visitor training centres, the students being regarded as having commenced the Health Visitor training when they enter the maternity course. The centres would necessarily have to work closely with the hospitals and local health authorities actually providing midwifery training where co-operation would obviously be needed. Midwives should play a large part in giving the training.

345. Since in our view the first part of the midwifery training does not provide a satisfactory preparation for Health Visitor students, we recommend that it should cease to be regarded as a qualification for entry to training as soon as sufficient maternity courses are established. As we have already indicated, fully qualified midwives would, of course, be admitted without further preparation.

Nurse Training

346. It is obvious—and all our witnesses would, we think, agree—that the work of a family visitor of the kind we have described will demand a good background of knowledge of the nature of illness and its effects and methods of treatment and rehabilitation. Doubts have been expressed by some as to whether the present requirements—registration as a general or sick children's nurse—are the best preparation for a Health Visitor. While the great majority of witnesses were in no doubt that Health Visitors must continue to be registered nurses, their views about nurse training generally indicate that the desirability of other arrangements is at least worth considering.

347. Experience with children, whether in sickness or in health, must be of advantage to the prospective Health Visitor. In our view, however, training as a sick children's nurse alone would not provide a sufficient background of knowledge for the wider field of work that we envisage for a family visitor. Very few children's nurses in fact go on to become Health Visitors each year. We do not recommend, that, for the future, registration as a

sick children's nurse alone should be recognised as a qualification for entry to Health Visitor training. Any specialised nurse training would, of course, also be of value—for example, mental nurse training. Only training of the character of general nursing, however, would be likely to give the opportunity for acquiring the background that will be needed. In using the term nurse, therefore, we refer to general nurses.

348. One of the objections to requiring Health Visitors to train first as nurses, as put to us, was the incompatibility of nurse training with Health Visitor training and practice. Hospital training has been institutional in character and has provided little or no opportunity for treating patients as whole persons, observing the social aspects of illness or gaining experience of domiciliary work. The long period spent in curative nursing has made the adjustment to a preventive outlook difficult. The necessary obedience of the student nurse to those in authority has produced an attitude difficult for some nurses to shake off when undertaking Health Visitor training. The unquestioned authority of nurses over their patients in hospital has made it difficult for some to refrain from adopting the same attitude in the relationship with clients at home. In our view, while there is force in these objections, it would be wrong to accept them as a valid generalisation applicable to all nurses. They would certainly, we think, be less applicable to the particular group of nurses who have the qualifications of intelligence and personality that we should wish to see in future recruits. The objections lose in strength, moreover, as hospital experience recedes in the memory and other experiences are superimposed. Many Health Visitors are now, and we hope in future will be, drawn from home nurses and domiciliary midwives, who, though still having a working relationship similar to that of hospital staffs, will have undergone the modifying experience of domiciliary training and practice. In any case, the training of nurses is now undergoing changes which should do much to alter the outlook of potential Health Visitors in future. The General Nursing Councils have revised their syllabuses recently with the object of keeping the preventive aspects in view throughout training and of arousing interest in preventive measures and social medicine from the outset. To quote from the guide to the new syllabus issued by the General Nursing Council for England and Wales:

> "The aim should be to give the student nurse an overall picture of the public health services, and all that they offer to the service of the community both in preventive and curative work, an outline view of the various provisions of the State in the way of family allowances, employment of disabled persons and other special categories, and to awaken her interest in the responsibilities of every nurse as a health teacher no matter where she may be carrying out her nursing duties. . . [Training should] bring home to the student the fact that the patient in whose care she is participating is an individual with family, economic and social problems resulting from his illness, and not merely an example of a certain disease being nursed in a bed in a hospital.
>
> The Health Service should be regarded as a whole, inter-relating the care given to the individual by all who participate, the General Practitioner, the Public Health Service and the Hospitals."

We are encouraged to think that in a few years, there may be less ground for doubting whether nurse-training is a suitable preparation for Health Visiting on the ground that it prevents the development of a preventive attitude of mind.

349. The objection is also raised that the knowledge the nurse acquires in hospital is more than the Health Visitor needs in some respects and less in others. Nurse training undoubtedly supplies much of the knowledge and experience that Health Visitors would need to carry out their functions, by whatever method they were trained. On the other hand it is true that at present very many nurses have insufficient experience of work with children or with the mentally ill, the tuberculous or of chronic illness generally and a great deal more has to be put into the Health Visitors' course on these subjects than should be necessary. It is also true that nursing and nurse-training are tending to become more and more technical in character and knowledge and skills are necessarily acquired that now have little practical application in Health Visiting and in future will have proportionately less if the Health Visitor becomes more involved in purely social action. We understand, however, that steps are already being taken to remedy deficiencies of experience in the form of experimental arrangements for students to receive part of their training in specialised hospitals. We have been informed by the General Nursing Council for England and Wales that they would see no objection to modification of the training so that over-concentration on the purely technical could be avoided in the case of the student who desired to go on to Health Visiting. The revision of the nursing syllabuses to broaden the student's outlook will not make any lighter the syllabus of Health Visitor training itself but the earlier approach to public health work will greatly help to introduce the student to the detail of preventive work. We are confident therefore that some at least of the objections to the nature of the content of nurse-training will also be removed or greatly reduced.

350. It can be argued that the nurse-training course is in any case too long and some would go so far as to say that nurse-training is not necessary at all, since Health Visitors will not be practising as nurses for the sick. We should, of course, see great advantages for Health Visiting if the nurse-training course were shorter and we return to this point later. For many years, however, it is unlikely to be practicable for hospitals to provide, side by side with nursing courses, any other form of training that will provide as effectively as nurse-training the essential background of knowledge for large numbers of Health Visitor students. On this ground alone it would be necessary to continue to regard nurse-training as an essential preparation for Health Visiting. There is, however, a more important consideration, the effect on the status of the Health Visitor. It is, of course, true that the reputation of any worker giving service to the public depends less on formal qualifications than on the quality of the service. Nevertheless, it is clear from the evidence presented to us by doctors, nurses and Health Visitors of wide experience that Health Visitors have been greatly helped in their relationships with members of the public and medical and nursing colleagues by being known as nurses. To earn such recognition they must follow a course of training that leads to registration. We should not think it practicable or wise to recommend that training and registration as a nurse should cease to be one of the qualifications of Health Visitors in future.

Public Health Training of Health Visitors

351. We do not think a useful purpose would be served by attempting ourselves to describe in detail the content of the Health Visitor course. These

are matters to which the training bodies ought to direct their attention. They will need to have full scope for frequent review of the content of and approach to training in a constantly developing social setting. We intend merely to deal with the general considerations that we think they might have in mind.

252. Witnesses' criticisms of the existing courses are to the effect that they are too short, too crammed, too theoretical and too little concerned with modern views on psychological aspects and family relationships. There is said to be a tendency to repeat matter covered in previous training. The range of subjects on which students may be examined is so wide that the training centres are said to be overmuch concerned with preparing students for an academic examination rather than with giving them a sound practical professional education. The nature and manner of providing practical experience has been singled out for criticism by some. We have examined the syllabus of the examining bodies and have reached the conclusion independently that while this undoubtedly covers the range of subject matter, most careful guidance would have to be given to training centres on the weight to be attached to particular subjects.

353. Generally, we think that the objects of training should be two—firstly, to provide the Health Visitor with the essential additional technical knowledge that she immediately needs for her own work and, secondly, to give her a clear picture of family welfare services and her part in them. No attempt should be made to give the student the full range of knowledge that an experienced Health Visitor has. It is enough that she should know the principles well and know where to look for further help as and when the need arises. Two things follow from this proposition. In the first place, students must be selected who can profitably follow such a course of study. We do not think an arbitrary limit should be imposed even if one readily suggested itself. A good academic record is not alone a qualification. Personality, temperament and adaptability count for at least as much. It is obvious that students must have the imagination and power of expression which will enable them to communicate orally or in writing their views on fairly complicated situations to colleagues with a wide range of interests. Selectors we feel should look for, as a minimum, intellectual ability sufficient to have enabled the student to reach the standard of the General Certificate of Education or its Scottish counterpart, coupled with personal qualities and enthusiasm. They will no doubt take full account of such evidence as the student's nurse and midwifery training record offers them. In the second place, we should not regard the newly qualified Health Visitor as fully competent to undertake at once the whole range of Health Visiting responsibilities. Great care should be taken—even in conditions of staff shortage—to introduce the new Health Visitor to the area, to each branch of work and to her colleagues in all services. An experienced Health Visitor —preferably the group adviser we have already envisaged—might be given special responsibility in this regard.

354. Nurse-training will have introduced Health Visitors to the nature of a wide range of illnesses and made them familiar with the structure of the body and the physical processes that lead to illness and students will have had experience of all sorts and conditions of people who are sick. Midwifery or maternity training will have given them insight into the problems of pregnancy, the lying-in period and infant feeding. The Health

Visitors' course will build on that foundation. It will continue to be important that the course should deal thoroughly with problems of child development. Attention should be paid to the wide variations that can occur in normal development and to the adjustment of advice to suit the individual case. Students will need to pay attention still to the common illnesses of children, particularly respiratory ailments and infectious diseases, to tuberculosis and the physical processes of ageing and the measures necessary to mitigate their effects. These are all matters with which Health Visitors will have a special concern. The problem of training, for the rest, seems to lie in the marshalling of medical knowledge already acquired and relating it to the facts of domiciliary practice. Like the general practitioner with whom she will work the Health Visitor will find the nature of illnesses met in hospital to be very different from those met in the home. She needs, therefore, to know more in a general way of the nature, frequency, early signs and course of common ailments, firstly so that she can be of maximum help to the general practitioner and secondly to help families effectively in the management of illness at home, co-ordinating her own work with that of the home nursing and home help services. She will need to have an insight into the after-effects of serious illness, the management of convalescence at home and rehabilitation. Naturally she should be introduced to the problems of long term disability, chronic illness and permanent handicap.

355. Practical knowledge of domestic management will be of great value to Health Visitors. The ability to help mothers to help themselves will simplify the health education problems of the Health Visitor. Under this head we should include, for example, household budgeting and marketing, healthy dietary, and other aspects of practical housewifery. Special attention will need to be paid to the adaptation of advice to the circumstances of different families and different areas, to the re-adjustment of rehoused families to new and unfamiliar conditions and to the prevention of accidents in the home. Practical exercises should if anything be devoted to the encouragement of resourceful improvisation in difficult circumstances.

356. In the course of her hospital training the student will in future be given some insight into the social services which are available to help the family in sickness. This will be a useful preparation for the introduction of the student to the social aspects of her profession, which will bulk ever larger. The Health Visitor, associated with general practice, with hospital after-care and rehabilitation, with the care of the chronic sick and the aged will be to a greater degree than at present concerned with the social implications of the disabilities or potential disabilities with which she is concerned. She will thus find it more and more necessary to have a working knowledge of the functions of other social services provided either by central and local government or by voluntary bodies. It is essential that she should have a general picture of the patterns of the inter-relationship of services, of the general objectives and method of approach of each service and of the kind of contribution which each can make to her problem and which she can make to theirs. The importance should be emphasised of studying the resources in a particular area and of knowing personally those to whom it may be necessary to turn for help so that sympathetic co-operation can be more rapidly and easily enlisted.

357. In all her work the Health Visitor will and ought to be concerned with family welfare in a wide sense. It follows that this should be the theme dominating her entire training. Whether the subject-matter is concerned primarily with the mother, the young child or school child, the ageing or aged, the sick, convalescent or handicapped, the family setting must be depicted and relationships within the family and between the family and society must be brought into due prominence. It will not always be the case that personal relationships will be a vital factor in the health education or social action in which the Health Visitor deals directly. The object of training should be to enable her to recognise the cases where they are important, not only to make her own work effective but to enable her to call others to her aid or—just as important—to bring cases to the notice of and advise other agencies more intimately concerned with a developing issue. Relationships are one aspect of the complex concept of " mental hygiene " on which most witnesses have laid much emphasis. We think that they are right to do so, but careful attention to training will be needed to avoid too great a stress on highly technical matter which calls for an arduous training beyond the scope of the general duties Health Visitor. We think a satisfactory solution may be obtained if training aims throughout at introducing Health Visitors to the psychological aspects generally of the cases with which they deal, the selection of the means of approach and the framing of advice to produce the desired results in the light of those aspects. A great deal will obviously turn on the establishment of the first contact and the development of a confidential relationship. Considerable attention should be paid to the technique of interview, whether at home or at the clinic. We have stressed the importance of " first-aid ". This implies also sympathetic listening perhaps merely to provide an outlet for a burden of hidden and irrational anxiety. It also implies the ability to stimulate, for many clients will have great difficulty in taking the first step. We have already suggested that the part the Health Visitor will take in the care of established mental illness will be essentially supportive though she may need to play a more active role in the absence of specialist help. We regard training for this as really a specialised aspect of " mental hygiene " calling for more guided observation and demonstration rather than for more extensive technical knowledge. We have indicated that not more than a broad and general introduction to psychological theory is needed. We make an exception in the case of mothers and children. While no attempt should be made to produce a technician, courses should concentrate on the psychological development of the children up to adolescence and especially on the relationship of parents and children, not only to improve the value of the Health Visitor's own work but to enable her to give the maximum help to the expert medical and non-medical staff concerned with the promotion of satisfactory mental development and the re-adjustment of departure from the normal.

358. The whole course of training should be practical in approach. The minimum of theory should be presented in lecture form and the aim should be to put before the student principles to be developed and illustrated by other means. We attach importance to private study, tutorials and case-studies for this purpose. Group discussions, in which experts (such as paediatricians, chest physicians, psychiatrists or specialist case-workers) present and discuss their own point of view on prepared cases, should figure prominently

in the curriculum. Demonstrations, observation visits, the carrying out of surveys and projects are other useful means of securing practical student-participation. It may be desirable to introduce certain blocks of technical study at an early stage because of their intrinsic importance or because they link up easily with earlier work. As soon as possible in courses, however, students should be introduced to practical work, whether in the clinic or the home. At a few centres selected cases are assigned to a student under supervision at an early stage; these are studied in practical work throughout the course and used as illustrative material at case discussions and as the basis for tutorials. There is much to commend this practice which might lead up to a period of semi-independent practical area work as a final stage in training. Much of the work the Health Visitor will do, however, will involve co-operation and the best form of training would no doubt be attachment to services for experience. If possible the student should be introduced to her mentors early and go to them for practical work as the course progresses, her tutor acting as the interpreter and co-ordinator of their teaching. It would be of particular advantage for a student to be attached for practical training to a Health Visitor who is experienced in working with a general practitioner.

359. Attention should be paid to the technical equipment of Health Visitors for their immediate work. As health educators they need to be familiar with all methods of propaganda. Their practical instruction in home visiting should give them a good introduction to the problems of on-the-spot education in the home. They need, however, also practical training in the techniques of group education in clinics—the use of visual aids, construction of displays and oral methods including not only talks to groups but the stimulation and guiding of group discussions which can be even more effective. The teaching of school classes, lecturing to public audiences and organisation of health education programmes call for some specialisation; while the basic course should touch on these aspects of teaching technique, it need not be concerned unduly with them. Health Visitors will be increasingly concerned with conference work of many descriptions. This will absorb little of the working week of most but all should be prepared, by practical training, for participation in case conferences with other workers, in care committees, parent teacher associations and mothers' clubs, etc. A point on which many Health Visitors are open to criticism is the quality of record keeping and report-writing. While it is generally agreed that Health Visitors acquire a comprehensive knowledge of the families they visit, they are often said to be at fault because they tend to report in stereotyped fashion only on the bare facts of the situation—often the environmental facts—and express judgments so tersely that other workers have difficulty in interpreting them. We think ample opportunities should be afforded to students to practise the very necessary art of studying the needs of the consumer, that is, in this case, looking for and presenting in the most suitable way the kind of information that the addressee of the report is seeking. Many Health Visitors have the opportunity to assist in surveys for the purpose of medical and social research questions. Their special training and unique opportunities for home visiting make them often invaluable for this purpose. This should not be lost sight of in training.

360. The length of time that can be given to the training of the Health Visitor necessarily, if regrettably, is a balance between the ideal and the practicable. There must be a limit to the amount of time that can be spent on training, determined partly by its content and objectives, partly by the possibility of attracting recruits to take it and partly also by sheer economy. At present a number of courses are still only six months in duration and this we regard as inadequate. A majority in England and Wales last nine months. Even if these were revised to reduce their purely theoretical content, more than all the time saved would be needed to include the practical teaching based on cases, the exercises in co-operation and the practical experience that we consider necessary. We think a reasonably adequate training could be given in a minimum of nine months and not more than twelve months should be needed, taking account of necessary holiday breaks. If three years are required for nurse training and three months for a maternity course—the choice we imagine of many future students—the total period of training would, as at present, be four years at least and not more than four years and three months (producing a certificated Health Visitor at a minimum age of about 23 years). Our recommendations would thus have the effect mainly of redistributing the content of the period. They would not reduce the length of training needed.

Integrated Courses

361. In any event, for many years, the majority of Health Visitors will still need to be recruited in the manner now customary, i.e. after taking a succession of trainings designed for different purposes, though one unnecessary diversion to institutional midwifery training will we hope increasingly be avoided by the establishment of the special maternity course. We are satisfied that there are no overwhelming objections to this arrangement and it should produce Health Visitors competent to do the work we envisage. We do not, however, regard this as the most satisfactory mode of training by any means. We have had the opportunity of discussing with Southampton University a proposed course which aims at giving students completely integrated training at the University and at St. Thomas' Hospital, leading to both registration as a nurse and the Health Visitor's certificate. This proposal is at an advanced stage and we know that another similar scheme is being planned. We strongly endorse experiments of this kind. Their appeal will at first be limited for they are necessarily intended for students entering the profession from school or University or from some other form of work and these are at present a small minority of the students coming forward. It is likely, however, that such courses, which from the outset keep the end in view and relate all theoretical and practical instruction to it, will be the only means of attracting substantial numbers of recruits directly into Health Visiting. In our view such courses would largely obviate the objections that are raised to the present training sequence. We should hope that eventually the majority of recruits would be trained on these principles.

362. The length of training is probably not a serious deterrent to good recruits under the present arrangements; they do not see before them a four year long (or longer) period of training but a comparatively short course leading to a new kind of work in which they have recently become interested. The outlook may be very different for those embarking on a career for

the first time. In practice, experiments in integration may not overcome the difficulty of the length of training. There would be every advantage in shortening the course if this could be done without detracting from its effectiveness. In this connection it is inevitable that consideration should be given to the time required to satisfy the requirements of nurse-training. In the case of the Southampton experiment, we understand, the General Nursing Council were able to approve, under the Nurses' Act, 1949, an experimental variation which would have reduced the period of training in hospital but advantage could not be taken of it to shorten the course. It may be possible for them to consider whether other variations could be introduced which would make effectively for shorter integrated courses.

363. Like most of our witnesses, we have been impressed with the possibities of the principles of training recommended by the Nurses' Working Party (1947), though not necessarily endorsing all its views. It will be recalled that a three year system of training was recommended, registration being granted after two years. In this period, eighteen months would be devoted to the fundamentals common to all fields of nursing and the remaining six months to concentrated study and training in a chosen field. Before being licensed to practise, the nurse would be required to complete satisfactorily a further year's work under supervision. Registration would presumably confer a common status, whatever form of specialised training was subsequently taken. It was an important proviso that nurses undergoing training should have full student status. This may not be practical politics for many years so far as the generality of student nurses is concerned.

It is of course for those concerned with nurse-training as a whole to consider, irrespective of the question of student status, how far it would be appropriate to move towards the principles advocated by the Nurses' Working Party. This is not a matter on which we are required or indeed are competent to make recommendations. We earnestly hope, however, that if under the Nurses Act, 1949, experiments in this direction are contemplated the marked advantages to Health Visiting of a shorter overall period of training will be borne in mind. It might well be that the most satisfactory field for initial experiments in a shorter training would be the integrated nurse-Health Visitor courses, designed as they are for workers who intend from the outset to devote themselves to preventive work and who—if current experience is any guide—are unlikely to make active nursing practice their vocation. We hope that the central training bodies will find it possible to discuss with the General Nursing Councils and any interested hospitals the practicability of such shorter courses leading to both qualifications.

364. There may well be room for a number of experiments in training, in what is truly a transitional stage, provided minimum standards of proficiency are set and parity of esteem is enjoyed by the staff trained in each experimental form. For example, if the length of the nurse-training element could be reduced, the way would be open for a longer public health element in the training. Such longer courses, held in closer association with the Universities, might have a greater appeal to those with higher educational qualifications. It might also be possible so to arrange courses that nurses, midwives or social workers need take only those parts that would complement their existing qualifications. All these and other possibilities should be examined side by side to determine what ultimately may be the best arrangements.

Further Training of General Duties Staff

365. One of the purposes of the Health Visiting course will be to impress the necessity for continued study. The Health Visitor herself has a responsibility to keep abreast of current developments in health and welfare and local authorities should help by giving her access to library facilities and relevant professional journals. Individual study and experience in isolation are, however, not enough. It should be one of the objects of administration to avoid the risks of isolation by affording Health Visitors the opportunity to meet for discussion of common professional problems both among themselves and with the medical and other staff of the authority. In-service refresher courses can help greatly to keep Health Visitors more closely informed of changes affecting their work and to formulate a common health education policy for the area. A wider field of contacts is, however, desirable. Experienced Health Visitors should have the opportunity of attending national conferences and meetings the objects of which are educational in character and which bear closely on the work of the Health Visitor. It is the practice of many authorities to arrange for the attendance of staff at approved refresher courses provided by such organisations as the Central and Scottish Councils for Health Education, the Royal College of Nursing and the Women Public Health Officers' Association. Reasonable expenditure on such staff training is now recognised for grant purposes. We think such courses will make a vital contribution in future to the re-training of Health Visitors to meet new tasks and they should be of good quality; approval of the courses should be one of the duties of the central training bodies. Employing authorities should ensure that all Health Visitors have the opportunity of attendance at such courses at least once every five years. This should apply equally to qualified and acting staff. Some expansion of the number of such courses will be necessary if all who need refresher training are to have it.

366. Many senior staff might welcome the opportunity of studying for a short time the problems of administering the service for which they are responsible. It would be a great advantage if courses, covering a wide field of health and welfare administration, could be held which administrative Health Visitors could attend with the heads of other services.

Advanced Training

367. We have recommended the establishment of a higher grade of field worker able to act as an adviser and consultant to the basic grade, to take over cases of greater difficulty, to assist in in-service training and to help in linking up the Health Visiting and social welfare services. In course of time we should expect that senior administrative officers would be chosen from this grade. Preparation for such posts must include experience of the practical problems of Health Visiting. We should expect that normally this would be obtained within about five years of first taking up work. Experience alone, however, would not suffice. We recommend that one or more Universities should be invited to institute courses to provide the advanced training that would be needed to carry out the recommended functions. These would have a status similar to that of sister-tutor courses now provided for hospital nursing staff and would be recognised by the award of a diploma. Sister-tutor

courses in England and Wales at present last two years. These are, however, partly in the nature of refresher training since, unlike Health Visitors, student sister-tutors will usually have had no further formal professional training since registration. The diploma course for Health Visitors on the other hand will have as its background a post registration course lasting about a year. We should not think it necessary for the advanced training to occupy more than an academic year. It would, of course, be a great advantage if the diploma course were related where suitable to the training of social workers, to ensure a common approach to common problems.

368. If Health Visitor training is to be fully effective it is essential that adequate tutorial staffs should be provided. The work of the tutor calls for wide knowledge of health and welfare work, including adequate knowledge of the work of the professions with which Health Visitors co-operate. Most of the formal teaching and lecturing to Health Visitors, we imagine, will be done by experts in their own fields called in for the occasion and they will play a large part in the less formal and equally important case conferences and discussions. The tutor's task will be to interpret, clarify and co-ordinate the teaching of others and to be constantly available to advise and guide the student throughout the course and to encourage further study. Especially she will be concerned with helping the student to apply her knowledge of principles practically to the cases which may be allocated for study. We have no doubt that tutorial posts must be held by experienced Health Visitors with proper qualifications. There is at present a shortage of qualified tutors and this will be felt acutely, if training places are rapidly increased. We consider therefore that it will be necessary to institute in the near future one-year courses of University standard in order to fill the immediate gap. When the deficiency has been made good, the need for regular specialised courses would obviously be greatly reduced. The advanced training recommended for group advisers, which would deal with staff training problems among other matters, should be an adequate preparation for the junior grade of tutor and on the long term this might be the ordinary mode of entry to such posts. Thus there would be eventually a uniform basis of qualification for all senior staff in Health Visiting. This might facilitate interchange between teaching and other staff and help to insure against any risk of divorce between teaching and practice.

CHAPTER XIII

THE ORGANISATION AND FINANCE OF HEALTH VISITOR TRAINING

369. We feel that modification of the present arrangements will be necessary in the future if Health Visiting and Health Visitor training are to develop as fast as we would wish. A variety of arrangements exists at present—and we see no objection in principle to varying approaches—but in most cases it is clear that the influence of the employing authority is dominant. There are,

of course, advantages in the organisation of training by employers, who know what their immediate needs are and can thus ensure that they will be satisfied. On the other hand there are risks that training will be over-influenced by local and temporary considerations and will not satisfactorily provide for a nation-wide service with a high enough standard of qualification nor forsee quickly enough the changes that may be needed to meet changing needs. Health Visiting, though a purely local authority service, is a service that all local health and education authorities must have. It is necessary, therefore, that all should be able to rely on a common standard of training and not one that may vary with the local needs of the service in the areas of the comparatively few training centres. It is fair, too, that all should contribute to the cost of training and not rely on the generosity of the few. Assisted training schemes are common but far from uniform, with the result that the opportunity for training may depend on the accident of location and first class recruits may accordingly be lost. The possibility of a too parochial view would no doubt be avoided if training was in purely professional and educational hands. There would be, however, a corresponding risk of a too academic approach to Health Visiting. This risk would be the greater because the scope of Health Visiting will extend more and more into social action with cases where some breakdown has already occurred and the fact that Health Visiting is basically concerned with the normal might easily be obscured. The term "employer" itself, moreover, must necessarily take on a wider meaning than "employing authority" since Health Visitors will be for a substantial part of their time working with or for other agencies, such as the hospitals and the general practitioner. These considerations lead us to suggest an organisation that, while ensuring representation of the employers' point of view, distributes responsibility over a wider field and brings to bear a wider view-point. We are loth to suggest new forms of administrative machinery. The changes we suggest, however, entail a uniform and different approach to financing which an organisation independent of the employing authority could more easily apply.

The Role of the Universities in Training

370. The courses of basic and refresher training that we visualise for general duties staff are not of University degree or diploma character. It is doubtful if all students could satisfy Universities of their fitness for such a course in any case and certain that Universities would not be able to absorb the large number of students requiring training. At present a number of Universities are closely interested in the Health Visitor training and in some cases the University plays a major part in the administration of the course or is wholly responsible for it. We consider that the co-operation of Universities in training will continue to be invaluable and we hope that as many as possible will give their help. We think it likely that Universities would generally wish to exert their influence both at the centre and locally by helping to co-ordinate training with other training courses to promote a common approach; by supplying advice from their wider and more detached view-point and, on the basis of research into health and welfare problems, on the method and content of training; and by arranging for the co-operation of University staffs. All courses should if possible be established in or near University centres to enlist the interest and help of the University within whose sphere of influence

the area is and to take the fullest advantage of the facilities that can be offered. We should, of course, hope that Universities would establish diploma courses themselves for the advanced training of group advisers.

Central Training Bodies

371. The primary function of the central training bodies should be to devise a national syllabus and to review it periodically in order to take account of changing needs and the problems of training centres. They should be responsible, taking account of the representations of local health authorities, for deciding in which areas training centres should be established and approving the constitution of the managing body, the administrative arrangements and the curriculum. They should have power to arrange for inspection of training and to withdraw approval, if necessary. The central bodies should actively encourage integrated training and should approve the maternity courses provided by centres and refresher courses provided by centres and others. They should arrange with Universities willing to help for diploma courses to be set up. They should have financial functions, which are described in paragraphs 378–383.

372. The bodies would determine the form of examinations for qualification and appoint examiners. The examination should be related as closely as possible to practical ability and the examining team should be carefully selected with this need in mind. Examinations should be held, if possible, at the centres themselves and account should be taken of course records and tutors' reports. We should see no objection to internal examinations, where a University had agreed to accept responsibility for the conduct of the training course and examinations. The central bodies should also be responsible for the issue to successful students of the certificate of qualification to practise. They might also do so on the basis of approved internal examinations and agree to the issue of certificates by training centres, if satisfied these would have equal esteem with the national certificate.

373. We should not think any central register necessary other than the central bodies' records of issue of certificates. We are concerned only with employment by a limited number of employers and the activities of Health Visitors as such beyond this field do not seem relevant. It would be a matter of importance, however, that staff of lesser qualification were not used for the Health Visitor's work. We, therefore, recommend that the Regulations requiring local health authorities to employ qualified staff unless the Minister of Health otherwise approves should be maintained and that similar Regulations should be made in Scotland. The problem of possible under-employment in the educational field cannot, we are advised, practicably be dealt with by Regulations; it will, however, be in the interest of the employing departments—usually, the local health authorities—to ensure that the time of skilled staff is wholly devoted to skilled work.

374. The constitution of the central bodies should adequately reflect the interests surrounding Health Visiting. It will clearly be necessary that employing, professional and educational interests should be represented. The general balance of representation should be such that the professional and educational interests—the Health Visitors' organisations, the training centres and the Universities—should together be in a slight majority. There are, however, a great many persons and organisations that will have a

deep interest in the efficiency of the service and therefore of training. It might be an advantage to constitute both an executive body of non-representative experts and an advisory body representing the interests most intimately concerned. Even so, it will be necessary for the central bodies to consult fairly widely beyond the field of representation.

375. We see no convincing ground for recommending the creation of a training organisation to cover Great Britain as a whole, provided that the separate organisations for England and Wales and for Scotland are sufficiently co-ordinated to ensure that the qualifications established by each are mutually acceptable. The Royal Society for the Promotion of Health and the Royal Sanitary Association for Scotland have borne admirably the thankless task of organising examinations for many years and their work has had a wide measure of acceptability. If they are willing to accept responsibility there seems no reason why they should not continue to be the examining bodies and add to their functions the other duties of the central training bodies that we have described above. It would be necessary for their existing committees to be re-formed with the broader basis of representation we have outlined. The Society and the Association would naturally then have some representation on them. If this arrangement proves unacceptable, we should recommend the establishment of entirely separate bodies, under the auspices of the Government departments concerned.

Health Visitor Training Centres

376. We should expect that the size of courses would generally be between about 25 places and 50 places. On this basis some 25 to 35 courses would be needed, many of them given at existing centres. More than one course might be given at some centres—as is done already at two centres in England. In some cases it might be difficult to organise practical work for the larger number of students at two-course centres. The difficulty would be lessened if such courses started at different times of the year; this would also reduce the risk of losing possible recruits. The administration of one or more courses should be the responsibility of a training centre committee. The committee would be responsible for devising a curriculum based on the national syllabus, and for staffing, premises, organisation of practical training and the welfare of students and would have the financial functions outlined below. They would be finally responsible for the selection of students, regardless of whether they had earlier been selected or sponsored by some other authority. No fixed criterion of selection need be set but fitness to take the course and to practise afterwards should be the sole considerations. In addition to providing for a basic Health Visitor course for nurses, the committee should consider the possibility of establishing integrated courses and would have to organise maternity courses and refresher courses, if necessary.

377. The training centre committee should be in many respects the counterpart of the central training bodies. Its constitution would depend on local circumstances, but it should adequately represent local interests. Special arrangements would be necessary when full responsibility for training had been accepted by a University. The size of the committee should not be such that effective executive action would be difficult: as in the case of the central body some less direct interests might well be represented instead

on a panel of advisers. We should expect that the Medical Officer of Health and Superintendent Health Visitor of the local health authority most concerned would be ex officio members and would play a prominent part in the organisation of training. The committee should also include some representative of the teaching staff of the course. In the case of integrated courses a link-up with the Area Nurse Training Committee would be necessary.

Financial Arrangements

378. At present the expenditure of local health authorities on training ranks for National Health Service grant (50 per cent.). The varying schemes of assistance to Health Visitor students similarly attract grant. The expenses of the examining bodies are met from fees, which in some cases are paid by students and in others by employers; the cost of—and therefore the arrangements for—examinations are necessarily limited by the fee that can practicably be charged to students. The ways in which expenditure is borne vary widely and lead to unfairness, both as between students and as between authorities.

379. Central training funds should be established which should be financed by examination fees and by contributions from all local health authorities. Contributions should be related to population or be made on some other agreed basis which would distribute the cost of training more fairly among the authorities, whose expenditure in this respect would we assume rank for grant. The funds should be administered by the central training bodies, whose estimates would no doubt require to be approved by the government department concerned.

380. The central training funds would meet the expenses of the central training bodies and training centre committees. They should also be used to cover the payments of standard training allowances by training centres to approved students. The amount of the training allowance should be a matter for negotiation in the appropriate Whitley Council but we should expect the arrangement to be on the following lines. Separate allowances might be necessary for those entering integrated courses and those entering post-registration courses. In the latter case we should expect the allowances to be not unduly below the starting salary of qualified staff. No charge would be made for tuition and allowances should suffice to cover all expenditure of the student other than the cost of examination fees and necessary books. Travelling expenses incurred in practical training should be refunded. Students attending a preliminary maternity course run by a training centre would be regarded for these purposes as having commenced Health Visitor training.

381. An approved student would be one who had already been accepted for employment and had agreed to serve with a particular local health authority on completion of training or who gave a general undertaking to serve with a local health authority in special need of staff. The student would be able to select such an authority from a list maintained by the central training bodies on the advice of Government departments. It would of course, be open to students to take up training independently of these arrangements; such students would not be restricted in their employment but would not benefit by training allowances or free tuition.

382. We have considered carefully whether approved students should be required to undertake service for a particular period. The suggested training allowance arrangements are generous, though not more generous than the situation demands. It is open to the sponsored student to select beforehand the area in which she wishes to work. Alternatively, if she is unsponsored she will have some choice of the area of shortage to which she might go. We recognise that in the last analysis service undertakings depend for enforcement more on honour than legal contract and that they have not always been successful in retaining staff for periods longer than the undertaking in some areas. Nevertheless, we think that it is in no way unreasonable to ask a student to serve for a period useful to the employing authority and that the great majority of students would willingly accept the obligation if the scheme were administered with understanding. We think that, as now is commonly the case, a period of two years' service should be required. Whether or not students subsequently remain depends not on undertakings but to a large extent on the ability of the employing authority to provide a satisfactory career in their area.

383. Refresher training and the secondment of staff for diploma courses should be the responsibility of the particular authority employing the staff. It might well prove necessary for the first few diploma students to be assisted by scholarships.

CHAPTER XIV

MANPOWER REQUIREMENTS

384. The size of the Health Visiting force depends firstly on the numbers required to undertake the volume of work demanded of Health Visitors, secondly on the numbers available who have the required qualifications and thirdly on the possibility of attracting recruits. We shall be dealing with the last two points in a further Chapter.

Case-loads

385. Various bases have been used for the purpose of calculating Health Visitors' case-loads. These have dealt with single aspects of the work only. For instance, in the case of maternity and child welfare the number of live births and the number of children under five years have been used. For the school health and tuberculosis services the basis has been a fixed number of children or patients. These figures have been based on common experience and would be a fair guide to the amount of routine work that one Health Visitor might expect to have to do in conditions as they have been in an average area for that particular aspect of the work. Some witnesses put forward tentative estimates at our request. One Health Visitor per 100 live births per year was suggested by two witnesses. One Health Visitor to 500 children under five years was suggested by another, but another estimated

that the figure might be 1 to 450. It was suggested by one witness that 1 to 700 infants and school children has been accepted in the past; others mentioned ratios of 1 to 1,500 school children or 4-6 Health Visitors to 10,000 school children. A figure of 1 to 30,000 population for tuberculosis was said to have been satisfactory in one county area. It will be seen that these itemised estimates vary widely. Witnesses realised that a "family visitor" would deal with all these problems and with a variety of others and some put forward estimates of the population with which such a visitor could deal. These were usually based on the itemised estimates and varied correspondingly. Their variety is best illustrated by indicating the approximate total number of Health Visitors that each estimate would require for Great Britain as a whole, with its population of about 50 million:—1 to 6,000 (8,300 Health Visitors); 1 to 5-8,000 (10,000-6,250 Health Visitors); 1 to 4,800 (10,400 Health Visitors); 1 to 2,500 (20,000 Health Visitors). The number of Health Visitors engaged in local health and education services and tuberculosis work in Great Britain according to our survey was about 9,400 (including administrative staff), of whom 6,700 were qualified and 2,700 were "acting" staff. Excluding home nursing and midwifery work done by some of these staff, they represented the whole time equivalent of about 8,000 Health Visitors. This would represent a ratio of one Health Visitor to about 6,400 of the population. It will be apparent that estimates based on population are not only far from easy to make but also may be misleading. It may be assumed that no change in working methods or conditions was taken into account in framing most of the estimates, which might in fact have been larger in that case. Taking the figures at their face value, however, very different deductions would follow about manpower problems. For instance, taking the lower estimates, the problem would be partly one of replacing untrained staff and partly of making re-adjustments between the National Health Service and School Health Service; this would call for a steady and slow expansion and little increase, if any, in training facilities. The higher estimates would, however, call for large-scale recruitment which would require wholesale re-organisation to be effective even within ten years. In the light of the evidence from all quarters of a shortage of staff and of our own view that the scope of the work should be expanded, we are satisfied that more staff must be needed. Though all these estimates are based on well-informed opinion we find it difficult to accept the lower estimates and we view the suggestions for very considerable increases with equal doubt.

386. We did not gain much information from the experience of the authorities themselves. From our inquiries it was apparent that where an establishment had been fixed, it had sometimes been related to one of the bases we have mentioned. More commonly, it expressed a hope for the immediate future of recruiting staff or was purely arbitrary. No pattern emerged to suggest that establishments generally were closely related to the needs of the area; where the figure might be expected to be high it was often low and conversely. The actual number of staff in post also varies unpredictably; no set of circumstances seems to guarantee success in obtaining and keeping staff. It is safe, merely, to assume that the great majority of employers want more—sometimes many more—staff than they have.

387. Despite the difficulties it is necessary to estimate approximately how many Health Visitors are needed to carry out with efficiency the duties we propose should be allocated to them. We can do this, of course, only within fairly wide limits since precise information about the needs of the population served is lacking and indeed it may be impossible to obtain valid data, so rapidly is the situation changing. The figures that result, though they may be useful for local consideration, cannot be regarded as necessarily valid for any particular area. Each local health authority has its own problem and accordingly, within obvious limits, its own set of social priorities. We think, however, that there would be a great advantage in a more uniform approach to the estimation of local needs than is now apparent. We suggest, therefore, that in each area an establishment should be arrived at that is based on a survey of ascertained needs, the approach to the problem being broadly on the lines proposed below.

388. Though it is convenient to express the required numbers of staff in terms of a ratio of staff to population or number of families, we think it impracticable to attempt to describe needs in terms of either. Not nearly enough is known about the nature and needs of families as units, about the number of families which may be at risk or about the way in which risks are distributed among families. Like the witnesses who presented estimates to us, therefore, we still find it necessary to begin by considering individual risks. On this basis, some estimate can be formed of the number of staff needed to cover the sum of the risks in the country as a whole. We think, however, that the methods adopted by our witnesses need to be elaborated and we also make certain assumptions. Firstly, we think it necessary to assume that steps will be taken to improve conditions of working so as to reduce to the minimum extraneous demands on the time of staff and increase their effectiveness to the maximum. Secondly, it is important to establish a standard of work so that not more is demanded of staff than they can reasonably undertake. If insufficient time is allowed, the quality of the work must suffer and eventually the point must be reached when no effective contact with clients is possible. Government statistics and the Nuffield survey suggest strongly that that point must have been reached by many Health Visitors. Thirdly, it is not sufficient to rely solely on the traditional bases of estimation—maternity and child welfare, school health services and tuberculosis. Other major classes of work with which the Health Visitor will be concerned must be taken into account and allowance made for new links with others in health and welfare work.

389. In every area we assume that in future Health Visitors will have a recognised field as general duties staff and they will not be expected to carry out less than the full responsibilities in that field. On the other hand they will not be given a miscellany of odd jobs merely because they are handy. They need to work as teams in an area small enough for them to know it thoroughly and for other workers and the public to know them, with a proper working base, proper communications and proper transport. We have been impressed by the amount of time spent unproductively in travelling. Decentralisation and transport facilities can reduce travelling time; minutes saved on each journey will add hours to the time available for visits. The use of a telephone may obviate many journeys altogether

(and much writing as well). Many Health Visitors spend much unproductive time at clinics and school sessions while engaged in duties that equally well could be done by others and that distracts them from their proper functions. Every effort must be made to avoid such wasteful practices.

390. We base our assumptions on the volume of work that may be expected in a standard working week of forty-four hours, consisting of eleven sessions of about 3½ hours (excluding meal times). We expect that, while the situation will vary from area to area and especially as between urban and rural areas, rather more time may need to be given to various commitments than hitherto. This would happen because the general duties staff will be covering not only maternity and child welfare but school and tuberculosis duties; they would make more of their contacts with clients at their clinic bases; and they would be in consultation to a greater extent with general practitioners, hospital staffs and other workers. We assume that some five-elevenths of the Health Visitor's time would be devoted to clinics, etc., in the local authority services, attendance at hospitals, ward rounds, case-conferences, discussions with doctors and others and routine office work. The remaining six-elevenths on average would be devoted to visiting. Home visiting is the key factor and we base our calculations on it. We have taken as an arbitrary unit a standard visit of 30 minutes, covering the time during which contact is made, associated travelling time and any other activities undertaken on the occasion of the visit. Obviously many visits would be shorter and a proportion of "no access" visits must always be expected, though we have made no specific allowance for them. If such a standard is assumed, a Health Visitor would know that she could devote at least that time on average to visiting one family for one immediate purpose and any others that might arise; she could, if necessary, spend some hours with a family without detriment to other clients. Our own survey suggests that on average 22·5 minutes were spent on each visit including associated travelling-time. A standard of 30 minutes is obviously not over-generous; it represents possibly an average of 10 minutes more on each visit if some effort is made to reduce travelling time. The assumptions together indicate that on average—the pattern will vary with conditions—Health Visitors should be able to carry out with full efficiency some 42 visits to different households in a week. In a working year of 47 weeks—the present position—a total of 1,974 say 2,000 visits would be possible.

391. We have next tried to estimate the total volume of work to be done. For this purpose we have considered first the principal clients with whom the Health Visitor will have to deal, viz., mothers, young children, school children and old people. We have assumed that, besides any immediate purpose which the Health Visitor may have, she would be concerned, as a family visitor, with any problem that affected any of these clients. Thus for these purposes she would be concerned, in the case of mothers and young children not only with advice about the health or ill-health of the children but with the mother's own health and with any care she may need as a result of illness. Similarly all matters, however arising, that affect school children, including the prevention of tuberculosis, or the aged, are considered to be aspects of the care of those classes of client. In addition, we have made estimates for two groups of adults—those not included in the special classes who are in need of after-care on discharge from hospitals

generally and tuberculous adults. A final class of clients—" miscellaneous " —is included to cover visits for any purpose other than the above. A " miscellaneous " estimate must necessarily be arbitrary ; we have made an allowance of 5 per cent. of all visits in this class.

392. We have next estimated the proportion of each class that is likely to be at risk and determined frequencies of visiting to each class. These frequencies are arbitrary in two senses. Even where they have had regard to current practice, for example, in maternity and child welfare, allowance has had to be made for the additional work resulting from care and after-care and association with the family doctor. (We have not attempted to define a class of client needing the services of a general practitioner only ; it has been assumed that the latter may be concerned in any type of case. Regard has been paid, however, to the visits which a Health Visitor might make as a result of working in co-operation with general practitioners when considering the proportion of each class which might be visited by her and the frequency with which these visits might be made.) In all cases it is assumed that reasonable discretion will be exercised in selecting cases for visit and that visits will rarely be made simply as routine.

393. For expectant mothers we have used the number of live births as a basis. It is assumed that contact will occur whether the mother is confined in hospital or at home. One visit is allowed for in respect of each expectant mother.

In the case of children under five years we have arrived at a figure of about four visits per year per child, taking account of all incidents in the health and welfare of the child and the mother. We should expect that, as now, visiting will be much more frequent in the early years and taper off before the fifth year. For example, half of all children under one year may need some six visits, most of the rest may need up to twelve visits and a few may need really intensive visiting. Similarly, children aged one to two years may need three to eight visits and older children one or two visits a year or rather more in some cases.

For school children we have assumed an average frequency of one home visit per child every four years. This would represent a considerable increase on present figures, because account must be taken of care and after-care in illness, more attention to B.C.G. inoculation, etc., and development of services for the handicapped, especially child guidance.

Tuberculosis in adults has been considered in three stages—pre-hospitalisation and contact tracing, four visits ; on discharge and one year thereafter, four visits ; for each succeeding year so long as necessary, two visits. It has been assumed that the patient treated at home may need more frequent visits during treatment but fewer thereafter.

In the case of the aged, figures are not easily assessable and nothing is known precisely about possible needs. Estimates are naturally arbitrary but we think our figures do not overstate the possibilities. We assume that needs may not arise before the age of 65, that they will not arise where the old person is still working and that needs will be less in the case of couples living together. We have assumed that those over 70 are usually not actively working. Old people in homes and hospital are excluded. For the aged we have taken a frequency of one visit a year to those over 65 without a partner (whether living entirely alone or with a family) and one a year to

twenty-five per cent. of married couples (who are usually younger and capable of mutual support). The frequency would be intended to cover all incidents of old age. The volume of visiting resulting represents we think a large increase over what is now done, but this is obviously a field in which rapid development may occur. We have had in mind especially the trend of policy which seems strongly to favour measures to avoid the need to admit or re-admit the aged and chronic sick to hospital or to other institutions. We agree that care at home is to be preferred and believe that the Health Visitor's work may greatly help to make this possible.

Classes of clients other than the above may be in need of help on leaving hospital following an acute or chronic illness. Precise figures are not available. We have assumed that the need for a single visit may be recognised in about one quarter of all discharges of clients not already mentioned. This is also a field in which rapid changes may occur.

The resulting estimated totals for England and Wales under the various heads (based on the estimated population at 31st December, 1953) are shown in round numbers in the following Table. (Figures for individual items for Scotland could not in all cases be provided in a form suitable for the present purpose.)

TABLE 15

Prospective Volume of Visiting by Health Visitors, England and Wales

England and Wales	Thousands	
Expectant mothers	700	
Children under 1 year	6,000	14,100
Children aged 1 year and under 2	3,300	
Children aged 2 years and under 5	4,100	
School children		1,600
Old people		2,600
Tuberculous patients (not otherwise counted)		900
Hospital after-care (not otherwise counted)		400
		19,600
Add 5 per cent. for miscellaneous visits		1,000
		20,600

The total of about 20·6 million visits represents about a 60 per cent. increase on the total number of visits now paid by Health Visitors in England and Wales. The pattern is broadly the same as at present with rather more attention paid to mothers and children of all ages and much more to the aged. This is a natural result of concentrating attention on groups that we now consider to be most vulnerable. In practice, developments may tend to alter this balance; we do not think they are likely however to reduce the total volume considerably.

394. Applying our standard of visiting (2,000 visits per year) to the total load of visiting (20·6 million visits), we arrive at an estimate of about 10,300 staff for England and Wales. On the assumption that a sufficiently similar situation exists in Scotland, the number required there would be about 1,200. The target figure for Great Britain would thus be about 11,500. This figure,

of course, represents the whole time equivalent of the whole and part-time staff to be engaged in Health Visiting. The number of whole time staff (or their equivalent) needed to reach the target figure is obtained by subtracting from it the whole time staff equivalent of all staff now doing Health Visiting, i.e., about 8,000 (Appendix V). The deficiency would thus be about 3,500 staff in all—3,350 in England and Wales and 150 in Scotland.

395. This is not, of course, the whole of the story. In Scotland, for example, the estimate suggests that the number of Health Visitors is already reasonably satisfactory and necessary improvements could be effected merely by reorganisation. It seems to us likely, in fact, that in certain areas the transfer of Health Visiting time from the school to the local health services would bring about an immediate relief of the pressure on the latter. It must be remembered, however, that a number of authorities already have a higher level of staffing than the target indicates would be needed on *average* (1 Health Visitor to 4,300 population). Since the transfer of staff from the more to the less fortunate areas would clearly be impracticable, a correspondingly higher rate of recruitment would be needed in understaffed areas. Moreover, the estimates do not take account of the effect of continuing and expanding the system of combined work in those areas where it is now favoured. If, say, one third of the time of a combined worker is given up to Health Visiting, three staff would have to be trained to expand the service by the equivalent of one trained Health Visitor.

396. In all areas account will have to be taken of the high proportion of unqualified staff ("acting Health Visitors") employed in the various fields that we recommend should be unified. This is particularly true of the Scottish Counties and the problem obviously may arise in many areas in Great Britain in the amalgamation of school with other staff. Often the existing "acting" staff will be giving valuable service as a result of their long experience. In some cases, however, it must be doubtful whether they will be fitted, even with some in-service training, for the full responsibilities of a general duties Health Visitor. It would clearly be unrealistic to dispense with the services of workers who can help in any way during a period of expansion and we advocate only that "acting" staff should cease to be engaged in future except with a view to early training.

397. It will be clear that we do not regard our estimate of 11,500 staff as a precise measurement of the number of Health Visitors who will be needed at some point in the future. Rather we regard it as a reasonable target to aim at and we have no doubt that better statistics and estimating may indicate a higher or lower figure. It is also clear that the average ratio of Health Visitors to population deriving from it (1 : 4,300) cannot be regarded as precisely applicable to any area of the country. In some areas, investigation may indicate a higher figure and (more rarely) a lower figure may be appropriate.

CHAPTER XV

THE PROSPECTS OF RECRUITMENT

398. We think the full development of the Health Visiting service may take as long as ten years, partly because expansion must be limited by resources, partly because the local implementation of the principles we have recommended may prove to be a lengthy matter. Within this period some twenty per cent. of existing qualified Health Visitors in England and Wales and more in Scotland may have left the service. These may well include many of the present administrative staff. In our view the aim should be to reach the approximate establishment we have suggested within ten years.

399. At present the number of students trained each year is around 640. The number of students has been fairly stable for the last three years but the total number of Health Visitors continues to rise slowly. To judge from the fall in the total number of dispensations to practise granted to "acting" Health Visitors by the Minister of Health, the increase is not due to a marked increase in "acting" staff. It is reasonable to assume that an annual entry of roughly 600 staff is sufficient to maintain the present numbers of qualified Health Visitors. To increase the total establishment by 3,500 in ten years, obviously more than 350 additional recruits would have to be taken in each year; it seems likely that at least 400 additional students would need to be recruited each year to cover losses among new staff over the period. In addition, we estimate that at least 100 places should be provided to take account of the retirement or transfer of "acting" staff and their replacement by qualified workers. The number of training places to be aimed at in the near future would therefore be:

	Places at Training Centres
Replacement of existing Health Visitors	600
Replacement of "acting" Health Visitors	100
Effective expansion	400
	1,100

To reach our suggested target, therefore, at least 460 additional recruits, would be needed annually (taking little or no account of failures or wastage in training).

The Recruitment Pool

400. Most of our witnesses—even those who placed their estimates of staff numbers high—were pessimistic about the chances of recruiting more staff. Usually their doubts were based on general propositions about available woman power based on forecasts made by the Ministry of Labour and National Service. In fact the general woman-power position is not really significant in relation to Health Visiting for the numbers required are tiny in comparison with the total labour force, though it must be expected that there will be heavy competition for the much smaller number of women who would be suitable for Health Visiting. On the other hand there is encouragement in the rising figures of school-leavers, and particularly in the increase in the number of women reaching the age of eighteen years which

will begin to appear in 1960. This may be of significance if as we hope Health Visiting becomes a profession which girls turn to soon after leaving school, rather than after training for a different type of work and perhaps spending some years in it.

401. The main factors in the immediate future, however, are the requirements that Health Visitors should be registered general nurses and should have a particular standard of general intelligence and aptitude. In the absence of special courses for intending Health Visitors embodying all elements in the training, recruitment depends largely on what happens to the pool of general trained nurses. Many take the general qualification for some other professional purpose (e.g., to reach higher posts in other branches of nursing). Many leave to marry or take up other work. Some of these may be willing to train as Health Visitors, but we do not think it would be realistic to rely on these sources for any substantial number of suitable students. By and large we must rely on nurses and midwives in active practice. As to the nursing services themselves, we understand the official forecasts of woman-power trends to imply that while the numbers entering nursing are not likely to rise they need not be expected to fall. We assume too that it will be accepted policy at least to maintain and if possible to increase the number of nurses available by encouraging recruits to enter and trained staff to stay in a nursing occupation. Every effort will, therefore (and we think rightly), be made to maintain the attractiveness of sick nursing as a career. It follows that for every nurse who leaves sick nursing a replacement must be found. Since Health Visitors are drawn from among nurses, recruitment must largely depend on the numbers entering nursing to replace them. We estimate the total number of general nurses working at about 65,000 (including midwives who are nurses and excluding existing Health Visitors and the staffs of specialised hospitals, such as mental hospitals). Each year some 11,000 additional names are placed on the Registers. At the same time we expect that about 10 per cent. of general nurses (6,500) will give up nursing. (This may be too low a figure in present conditions but there are signs that nurses are staying longer in hospital work.) Thus of the new entrants at least 6,500 will be absorbed in replacement of nurses for the hospital and domiciliary services. Probably some 4,500 nurses therefore would be available annually to meet any expansion of those services and to staff other services, such as Health Visiting. We have estimated that some 50 per cent. of nurses are likely to be qualified to enter Health Visitor training. What proportion of the 4,500 available nurses would be so qualified must be problematical. It would not be safe to assume a figure any higher than the general average. Training centres are likely at most, therefore, to be able to draw on about 2,250 nurses annually to fill 1,100 places. It must be doubtful if they could succeed. It will, therefore, be essential to turn for recruits to those who have left nursing —not a hopeful prospect—or to those who have recently left school or University or who are already in employment. In both cases, Health visiting would be competing in the open market. Difficult as the manpower situation is, we think there are good chances of success if a determined effort is made.

The Stimulation of Recruitment

402. More needs to be done to bring to the notice of potential recruits the value and possibilities of Health Visiting. A direct approach should be made

to the most likely sources by the local authorities, individually or through their associations, with the help of the Government departments concerned.

403. The main source of recruits for some time, however, will continue to be trained nurses. An appeal is already made to this source by the Ministry of Labour and National Service through its Nursing Appointments Service. Local advertising of posts can be effective and most authorities already advertise in the nursing press. It is doubtful, however, if many nurses read such advertisements unless they are already seeking public health jobs. More effective and better co-ordinated advertising and publicity directed to trained nurses generally is clearly needed. The nursing press which already deals to an increasing extent with public health matters would be an admirable vehicle for general publicity. This might be backed by a central advisory centre, able to deal with queries and refer inquirers to the most suitable training centre or employer.

404. The smaller but we believe growing source of recruits who are not nurses must also be tapped. Publicity aiming at recruitment for nursing, midwifery or work in the social field should refer with proper emphasis to the attractions of Health Visiting as a career, whether entered as now through nurse training or in the future through integrated courses. It is particularly important that information about Health Visiting and the training facilities should be available to school-leavers. The Youth Employment Service and schools can give invaluable help in the course of their careers advice and vocational guidance work.

405. Often recruits—whether already nurses or not—may be willing to come but naturally unwilling to wait for a training place, perhaps without other employment. Local authorities can help themselves by finding suitable employment for potential recruits in the interim. Nurses willing to take up Health Visitor training can often be found jobs in maternity and child welfare or school clinics until a training place is available. As integrated courses and a lower age of entry to Health Visitor training become more common, however, it will be more important to attract and keep the interest of school-leavers until they can take up training at a minimum age of eighteen years. Pre-nursing courses already help to bridge the gap between school and nurse training and some Health Visitor students may be drawn from this source. One employing authority at least, however, has found it useful, as do many hospitals, to find openings for potential students in their health services, till they can start training. Nursery nursing has also been a useful source of recruits.

406. The organisation of courses should take account of the recruitment problem. The establishment of integrated courses is essential if an appeal is to be made for direct entrants to Health Visiting. It would be an advantage to stagger the commencement of courses generally through the year to avoid any gap between recruitment and training.

Improvement of Status and Conditions of Work

407. We are sure that the best recruiting agent is the Health Visitor herself ; and if each could persuade a nursing colleague to take up the work there would cease to be a recruitment problem. Health Visitors must be sure, however, that they know what they are offering and that it is in fact

attractive. Employers generally must offer a full range of work and a full measure of independence to staff, who should be answerable to their own immediate professional head, without constant detailed supervision. Recruits will thus know what is expected of them in whatever area they work. We have recommended a decentralised area basis of organisation with proper communications and means of private consultation. At the least, adequate transport is essential; something must be wrong if in the aggregate as much time is spent in travelling as in visiting. In order to devote their full time to their proper work, Health Visitors must be relieved of all unnecessary duties and others, if necessary, engaged to do them. Chaperonage, clerical duties, food selling, minor treatments and inspections and other odd jobs are *not* health education and social advice and such duties should not be required of Health Visitors, merely because they can conveniently do them. This will often mean that staff other than Health Visitors will need to be engaged to undertake work of which Health Visitors ought to be relieved; but this would be true economy. Finally, Health Visitors should not be expected to carry such a caseload or burden of automatic visits that they cannot carry out their work effectively to their full professional satisfaction. The needs of the area should be reviewed and the work and establishment of Health Visitors adjusted accordingly.

Financial Incentives

408. It will be clear that we attach great importance to the purely vocational attractions of Health Visiting. Unless the vocational satisfaction is apparent, higher salaries will not alone attract suitable, competent and responsible staff, and it is useless to engage staff of lesser quality merely to make up numbers. We think it is true to say, moreover, that the sense of frustration that many Health Visitors feel was apparent long before new pay settlements altered their material prospects relative to nurses. Nevertheless, we are sure that the present salary arrangements are highly unlikely to attract suitable recruits in adequate numbers either from the schools, from the nursing and midwifery services or from other employments. It is not our function to consider salary scales in detail. This essential but unenviable task lies with the negotiating bodies. A glance at the variety of interests of which they must take account suffices to illustrate their difficulty. We recommend most strongly, however, that a review of salary scales should now be made in the light of the pressing problem of recruitment. It should not wait on the implementation of our other recommendations. We think the following matters are relevant to such a review.

409. Health Visiting is not functionally comparable with any other professional work at all points. Health Visitors, as such, do not practise sick-nursing and a functional comparison for salary purposes with the ward-sister, for example, is pointless. The Health Visitor's training has not, moreover, quite the same objects as that of the social worker. The type of woman wanted is ideally one who might go far in either profession. In relation to nursing, it is the nurse whose general ability would enable her to attain or go beyond the rank of ward-sister who must be attracted. It would be from nursing that most recruits will be drawn for many years and the decisive factor is the requirement that part of the training shall be as a nurse. It seems to us therefore that the salary scale of the general duty

grade should be attractive to nurses who are capable of accepting responsibilities that would go with promotion to ward-sister and above. It is important that staff acting as Health Visitors without the qualification should have a positive incentive to take the training. The general duties scale therefore should clearly offer a definite advantage to the qualified Health Visitor. We hope that the trend will be towards an earlier age of entry than at present; eventually, we should like to see a majority of students entering before the age of twenty-five, though we do not, of course, contemplate an artificial upper age-limit. For some time, however, recruits will have to be drawn from a rather higher age-group and consideration should be given to measures to attract older women whose earnings and responsibilities are correspondingly greater.

410. The higher posts open to Health Visitors include those of superintendent and deputy superintendent (of a local health or education authority service or, in a County, a divisional area), three grades of tutor and miscellaneous posts carrying a small allowance for additional responsibility. The last named include the posts of centre superintendent, senior Health Visitor, senior tuberculosis visitor, senior school nurse, administrative assistant, etc. These posts no doubt fall largely to those whose career has been mainly in Health Visiting. In addition, Health Visitors can compete for posts as superintendent and deputy superintendent nursing officers, in some areas, where one officer is responsible for nursing and midwifery as well as Health Visiting services. All the scales for higher administrative staff depend on the number of staff for whose work they are responsible. Thus superintendent nursing officers have scales that are identical (with one exception) with those of Superintendent Health Visitors but since they are likely to be responsible for more staff they are likely to have higher salaries. At the other end of the scale, superintendents who have fewer than ten staff are ranked as senior Health Visitor with the responsibility allowance.

411. On these arrangements generally we need only observe that the implementation of our recommendations for unifying Health Visiting, tuberculosis visiting and school nursing services will eventually make a review necessary. We think further consideration may then need to be given to the basis of administrative salaries. It does not seem to us that the relation of scales to the actual number of staff superintended fairly reflects the responsibilities of senior staff, whose work depends on the needs of the area. If the needs are great the fact that there is a staff shortage or that other services are undeveloped may demand more not less effort from them. It would be unsatisfactory to relate staff salary scales directly to population or to staff establishments in their present form. We suggest that the methods we have outlined in Chapter XIV for arriving at an area staff establishment should eventually be adopted for salary purposes—improved as necessary.

412. A new scale will need to be considered in due course for the group adviser grade which will occupy a position between the allowance post holders and the administrative staff. We have suggested that the grade should be considered to be on a par with the junior grade of tutor. Higher tutorial grades are already roughly on a par with those of superintendent Health Visitors of large authorities. We think there is merit in the principle of equating the salaries of tutors with those of field and administrative staff to facilitate interchange. Suitable tutors might thus have the oppor-

tunity if they wished to take for a time administrative or group adviser posts in order to refresh their knowledge of practical problems, while a period of responsibility for tutoring might be helpful also to administrators or group advisers.

413. It has also been suggested to us that the field Health Visitors to whom students are attached for practical experience of visiting should have some reward for essential work that can be, properly done, an arduous task. We think that part of the time of such staff might be regarded as allocated to the training centre, which would pay a suitable allowance. The training centre would, of course, approve the Health Visitors taking part and would have to have opportunities for discussion with them of the way in which the work was to be carried out.

Appendix I

List of witnesses who submitted memoranda and gave oral evidence

Employing Authorities
- Association of Municipal Corporations
- (1) Association of Education Committees
- Association of County Councils in Scotland
- County Councils Association
- Convention of Royal Burghs of Scotland
- Counties of Cities Association of Scotland
- (1) London County Council
- (1) Welsh Joint Education Committee

Health Visitor Interests
- (3) Royal College of Nursing
- Scottish Health Visitors' Association
- (3) Women Public Health Officers Association

Medical Interests
- British Medical Association
- (1) British Tuberculosis Association
- (3) Society of Medical Officers of Health (English and Scottish Branches)

Nursing and Midwifery Interests
- (2) Central Midwives Board
- (2) Central Midwives Board for Scotland
- (2) General Nursing Council for England and Wales
- (1) General Nursing Council for Scotland
- (3) Queen's Institute of District Nursing
- Royal College of Midwives

Social Welfare and Casework Interests
- Association of Psychiatric Social Workers
- Association of Children's Officers
- Institute of Almoners
- Society of Mental Welfare Officers
- (2) Scottish Children's Officers' Association
- Scottish Welfare Officers' Association (Mental Health Interests only)

Training Bodies (See Note 1)
- (1) Royal Sanitary Association of Scotland
- Royal Society for the Promotion of Health (Royal Sanitary Institute)
- (3) Standing Conference of Health Visitor Training Centres Approved by the Minister of Health.

Universities
- (3) Joint University Council for Social Studies and Public Administration
- (1) University of Hull
- (1) University of Southampton (Joint Board for the Training of Health Visitors)

Notes: 1. The Counties of Cities Association of Scotland also represented Scottish Training Centres.
2. Witnesses marked (1) provided written memoranda only; those marked (2) gave oral evidence only.
3. Supplementary evidence was received from witnesses marked (3) following discussions.

APPENDIX II (*a*)

Number of Health Visitors and School Nurses, Whole-time Staff Equivalent and Home Visits for Selected Years (Official Statistics)

1. *ENGLAND AND WALES*

Year	1935	1945	1947	1949	1952	1954
1. Number of live births during year	598,756	685,273	886,820	731,172	673,286	673,212
2. Number of children under 5 years (mid-year)	2,834,400	3,128,000	3,522,000	3,701,000	3,506,000	3,326,000
3. Number of children on roll at schools maintained by local education authorities (at 31st January of following year) (*a*)	5,719,112	5,039,734	5,409,822	5,710,468	6,273,922	6,565,000
4. *Health Visitors*						
(i) Number employed at end of year (*b*)						
whole-time	n.a.	n.a.	n.a.	1,655	1,537	1,161 (*d*) 479 (*e*)
part-time				4,197	4,707	4,979 (*d*) 90 (*e*)
Total	5,684	5,846	6,039	5,852	6,244	6,140 (*d*) 569 (*e*)
(ii) Whole-time staff equivalent	2,692	3,052	3,181	3,745	4,122	3,885 (*d*) 507 (*e*)
(iii) Number of nurses employed as Health Visitors by virtue of dispensation (*c*)	—	—	—	1,350	1,061	815
(iv) Number of visits carried out by Health Visitors (excluding School Health Service)...	8,249,965	8,069,173	8,414,597	10,314,430	11,506,658	11,601,293 (*d*) 645,711 (*e*)
(v) Percentage of visits relating to maternity and child welfare	100	100	100	90	87	87 (*f*)
5. *School Nurses*						
(i) Number employed at end of year	5,644	5,137	5,273	5,134	5,690	6,157
(ii) Equivalent whole-time	n.a.	2,129	2,506	2,516	2,519	2,565
(iii) Number holding Health Visitors Certificate	n.a.	n.a.	n.a.	n.a.	3,902	4,407

(*a*) Number at 31st March, 1935, includes non-maintained special schools.

(*b*) Figures of whole-time Health Visitors for 1949 at least include some employed partly as school nurses. Figures for 1952 and 1954 should show as whole-time health visitors only those *not* employed partly as school nurses.

(*c*) Under the National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948. Before 1948 dispensations were under Regulations of 1930. Prior to 1953, figures were the result of a particular enquiry, and relate to some point during the year, not the end of the year.

(*d*) General duty health visitors
(*e*) Tuberculosis visitors ... } Previous figures relate to " health visitors ", and the extent to which tuberculosis visitors were included is not known.

(*f*) Percentage based on visits by general duty health visitors only. If visits by tuberculosis visitors were included, the percentage would be 83 in 1954.

APPENDIX II (*b*)

Number of Health Visitors and School Nurses, Whole-time Staff Equivalent and Home Visits for Selected Years (Official Statistics)

2. *SCOTLAND*

Year	1935	1945	1947	1949	1952	1954
1. Number of live births during year	87,928	86,924	113,147	95,674	90,422	92,315
2. Number of children under 5 years (end of year)	407,100	421,737	449,171	472,400	450,100	432,022
3. Number of children on School Registers at 31st July	823,445	n.a.	729,617	783,828	795,783	827,845
4. *Health Visitors and School Nurses*						
(i) Number employed at end of year						
whole-time	462	678	692	768	839	883
part-time...	623	600	n.a.	n.a.	673	679
Total	1,085	1,278	n.a.	n.a.	1,512	1,562
(ii) Number of visits carried out by Health Visitors and School Nurses (*a*)	1,005,000	1,155,000	1,299,757	1,780,720	2,075,571	2,069,352
(iii) Percentage of visits relating to maternity and child welfare	100	100	100	84	81	81

(*a*) For the years 1935 and 1945, visits relate to maternity and child welfare only. For the years 1947, 1949 and 1952, the figures quoted include School Health Service visits. For the year 1954, School Health Service visits are excluded.

NOTES

1. The figures for part-time health visitors include women employed whole-time who undertake health visiting as part of their duties, and women employed part-time and occupied wholly or partly on health visiting duties. For Scotland, figures are given for health visitors and school nurses jointly.
2. No " whole-time staff equivalent " figure is available for part-time Health Visitors and School Nurses in Scotland.
3. No qualifications have been prescribed for Health Visitors and School Nurses in Scotland.

APPENDIX III (*a*)

Inquiry of Local Authorities

AGE AND CIVIL STATUS OF HEALTH VISITING STAFF

(Staff employed at 31st December, 1953)

ENGLAND AND WALES

1. COUNTIES

Category of Staff	Civil Status	Up to 25 years	25 and under 30	30 and under 35	35 and under 40	40 and under 45	45 and under 50	50 and under 55	55 and under 60	60 and under 65	65 and over	TOTAL
Qualified Health Visitors	Single	8	260	528	589	706	583	305	214	88	13	3,294
	Married	2	63	112	136	177	147	70	26	16	1	750
	Widowed		1	8	19	29	21	14	11	6	4	113
	TOTAL	10	324	648	744	912	751	389	251	110	18	4,157
Acting Health Visitors	Single	4	40	68	73	88	135	137	150	69	15	779
	Married	3	30	40	65	91	113	76	56	17	2	493
	Widowed		1	1	2	8	16	22	27	14	3	94
	TOTAL	7	71	109	140	187	264	235	233	100	20	1,366
Tuberculosis Visitors	Single	1	4	7	10	19	19	10	4	5	1	80
	Married		3	6	8	13	9	1	4	2		46
	Widowed					1	2	3				6
	TOTAL	1	7	13	18	33	30	14	8	7	1	132

2. COUNTY BOROUGHS

Category of Staff	Civil Status	Up to 25 years	25 and under 30	30 and under 35	35 and under 40	40 and under 45	45 and under 50	50 and under 55	55 and under 60	60 and under 65	65 and over	TOTAL
Qualified Health Visitors	Single	12	183	244	275	213	203	104	97	26	1	1,358
	Married		50	61	58	56	51	25	10	4		315
	Widowed			11	7	10	11	2	9	2		52
	TOTAL	12	233	316	340	279	265	131	116	32	1	1,725
Acting Health Visitors	Single	15	14	25	23	35	35	31	41	6	1	227
	Married	11	38	35	41	46	34	28	6			238
	Widowed			3	2	9	6	7	6	1	1	35
	TOTAL	26	52	63	66	90	75	66	53	7	2	500
Tuberculosis Visitors	Single		4	4	9	1	6	10	7	2		43
	Married		2	9	10	11	10	6	5	1		54
	Widowed			2		1	2	1	2			8
	TOTAL		6	15	19	13	18	17	14	3		105

APPENDIX III (*b*)

Inquiry of Local Authorities

SUMMARY OF TABLE I

AGE AND CIVIL STATUS OF HEALTH VISITING STAFF

(Staff employed at 31st December, 1953)

SCOTLAND

Category of Staff	Civil Status	1. COUNTIES: Up to 25 years	25 and under 30	30 and under 35	35 and under 40	40 and under 45	45 and under 50	50 and under 55	55 and under 60	60 and under 65	65 and over	Total	2. CITIES AND LARGE BURGHS: Up to 25 years	25 and under 30	30 and under 35	35 and under 40	40 and under 45	45 and under 50	50 and under 55	55 and under 60	60 and under 65	65 and over	Total
Qualified Health Visitors	Single		20	44	63	49	49	33	28	10		296		39	80	99	87	76	48	37	6		472
	Married		1	4	2	7	4	5				23		2	6	6	3	9	1	2	1		30
	Widowed					4	3		2	1	1	11			3	2	2	3	2	3	4		19
	Total		21	48	65	60	56	38	30	11	1	330		41	89	107	92	88	51	42	11		521
Acting Health Visitors	Single	6	57	80	60	66	69	64	41	24	3	470	6	8	7	12	11	8	8	6	2		68
	Married	1	4	10	4	11	14	11	6	3	1	65		1	7	2	3	9	1	1			24
	Widowed				1	6	4	8	2	3		24					2	2	2	3			9
	Total	7	61	90	65	83	87	83	49	30	4	559	6	9	14	14	16	19	11	10	2		101
Tuberculosis Visitors	Single				1							1						1					1
	Married			1		2	1		1			5			1	1		1					3
	Widowed						2					2											
	Total			1	1	2	3		1			8			1	1		2					4

NOTE: The figures for Scottish County Councils *exclude* health visiting staff employed by Moray and Nairn Joint County Council.

APPENDIX IV (*a*)

Inquiry of Local Authorities

HOME VISITING DUTIES ALLOCATED TO HEALTH VISITING STAFF

(Staff employed at 31st December, 1953)

ENGLAND AND WALES

1. COUNTIES

Category of Staff	Combination of Duties													Total	Staff Employed By		
	H	T	S	HT	HS	HTS	HN	HSN	HTSN	HSM	HTSM	TS	Other		Health Department only	Education Department only	Both Health and Education Departments
Qualified Health Visitors	283	162	12	40	1,611	1,184	86	222	156	22	116	11	20(*a*)	3,925	584	12	3,329
"Acting" Health Visitors	8	131	426		45	44	256	293	286		2	3	2(*b*)	1,496	395	176	675
Total	291	293	438	40	1,656	1,228	342	515	442	22	118	14	22	5,421	979	188	4,004

2. COUNTY BOROUGHS

Qualified Health Visitors	624	60	118	124	364	323							1(*c*)	1,614	809	118	687
"Acting" Health Visitors	46	104	381	4	39	12				1		2		589	154	381	54
Total	670	164	499	128	403	335				1		2	1	2,203	963	499	741

NOTES: In the above table: H = Health Visiting
T = Tuberculosis Visiting
S = School Nursing
N = Home Nursing and/or Midwifery
M = Mental Deficiency Visiting

(*a*) — 13 HTM: 7 HTSNM
(*b*) — 2 SN
(*c*) — 1 VD almoner

APPENDIX IV (*b*)

Inquiry of Local Authorities

HOME VISITING DUTIES ALLOCATED TO HEALTH VISITING STAFF

(Staff employed at 31st December, 1953)

SCOTLAND

1. COUNTIES

Category of Staff	Combination of Duties										Total	Staff Employed By		
	H	T	S	HT	HS	HTS	HN	HSN	HTSN	Other		Health Department only	Education Department only	Both Health and Education Departments
Qualified Health Visitors ...	4	8	24	36	45	70	7	32	64	7(*a*)	297	60	24	213
" Acting " Health Visitors ...	2	8	24	5	6	18	40	160	290	10(*b*)	563	55	24	484
Total	6	16	48	41	51	88	47	192	354	17	860	115	48	697

2. CITIES AND LARGE BURGHS

Qualified Health Visitors ...	187	59	30	39	44	65		8			432	285	30	117
" Acting " Health Visitors ...	8	6	8	8	2	13	21	12		2(*c*)	80	45	8	27
Total	195	65	38	47	46	78	21	20		2	512	330	38	144

NOTES: 1. In the above table: H = Health Visiting
T = Tuberculosis Visiting
S = School Nursing
N = Home Nursing and/or Midwifery
M = Mental Deficiency Visiting

(*a*) — 2 HSNM; 3 HNM; 2 N only
(*b*) — 10 HSNM
(*c*) — 2 HTN

2. The above table *excludes* health visiting staff employed by Moray and Nairn Joint County Council.

APPENDIX V (*a*)

Inquiry of Local Authorities

RANGE OF DUTIES ON WHICH HEALTH VISITORS AND OTHERS ARE EMPLOYED AND WHOLE-TIME STAFF EQUIVALENT

(Staff employed at 31st December, 1953)

ENGLAND AND WALES: 1. COUNTIES

Category of Staff	Actual Number of Staff	Whole-time Staff equivalent	Administrative and Supervisory Staff		Clinic and Home Visiting Duties											Other Home Visiting Duties
					Ante-natal		Other Maternity and Child Welfare		Schools		Tuberculosis		Home Nursing and Midwifery		TOTAL of "B" columns only	TOTAL "B" only
	(1)	(2)	A (3)	B (4)	A (5)	B (6)	A (7)	B (8)	A (9)	B (10)	A (11)	B (12)	A (13)	B (14)	(15)	(16)
SECTION 1 *Health Visiting Staff*																
Qualified health visitors	4,138	4,082·79	247	199·69	3,326	283·84	3,716	1,836·34	3,354	943·17	1,714	282·76	463	285·56	3,631·67	251·75
"Acting" health visitors	1,319	1,271·61	3	3·00	568	39·18	910	222·91	1,053	441·83	390	12·76	819	520·78	1,237·46	30·81
Total, Section 1 ...	5,457	5,354·40	250	202·69	3,894	323·02	4,626	2,059·25	4,417	1,385·10	2,033	295·52	1,282	806·34	4,869·13	282·56
SECTION 2 *Nursing Staff and other Staff employed on home visiting duties*																
Tuberculosis visitors ...	132	128·00	4	1·00					1	0·20	132	126·80			127·00	
School Nurses... ...	136	127·90							136	126·90					126·90	1·00
Midwives and Home Nurses	7,468	7,166·07	201	173·47	2,574	285·17	385	15·57	78	5·75	233	3·00	7,271	6,643·73	6,953·22	39·38
Other Nurses including Clinic Nurses ...	205	156·92			76	21·30	152	59·12	142	69·50	16	5·10	1	0·30	155·32	1·60
Social and Welfare Workers	726	635·19	34	24·10			1	1·00	10	8·50	29	40·95			50·45	560·64
Total, Section 2 ...	8,667	8,214·08	239	198·57	2,650	306·47	538	75·69	367	210·85	430	175·85	7,272	6,644·03	7,412·89	602·62
GRAND TOTAL ...	14,124	13,568·48	489	401·26	6,544	629·49	5,164	2,134·94	4,774	1,595·85	2,463	471·37	8,554	7,450·37	12,282·02	885·18

NOTES: 1. The above table *excludes* health visiting and other staff employed by Radnor County Council.
2. In columns (3) to (16): A = "Number employed"; B = "Whole-time staff equivalent".

APPENDIX V (*b*)

Inquiry of Local Authorities

SUMMARY OF TABLE III

RANGE OF DUTIES ON WHICH HEALTH VISITORS AND OTHERS ARE EMPLOYED AND WHOLE-TIME STAFF EQUIVALENT

(Staff employed at 31st December, 1953)

ENGLAND AND WALES: 2. COUNTY BOROUGHS

Category of Staff	Actual Number of Staff	Whole-time Staff equivalent	Administrative and Supervisory Staff		Clinic and Home Visiting Duties											Other Home Visiting Duties
					Ante-natal		Other Maternity and Child Welfare		Schools		Tuberculosis		Home Nursing and Midwifery		TOTAL of "B" columns only	TOTAL "B" only
			A	B	A	B	A	B	A	B	A	B	A	B		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
SECTION 1 *Health Visiting Staff*																
Qualified health visitors	1,724	1,701·19	131	119·49	1,073	107·10	1,400	914·18	803	335·81	503	95·38	9	1·18	1,453·65	127·64
"Acting" health visitors	497	491·68	10	8·25	30	4·83	94	54·31	440	410·25	16	1·78	1	0·18	471·35	11·96
Total Section 1 ...	2,221	2,192·87	141	127·74	1,103	111·93	1,494	968·49	1,243	746·06	519	97·16	10	1·36	1,925·00	139·60
SECTION 2 *Nursing Staff and other Staff employed on home visiting duties*																
Tuberculosis visitors ...	112	109·05	1	1·00					2	1·00	111	107·05			108·05	
School Nurses ...	119	114·37					3	1·75	117	112·62					114·37	
Midwives and Home Nurses	3,340	3,138·00	212	195·62	569	99·49	124	16·00	22	1·00	112	3·19	3,146	2,815·69	2,935·37	7·01
Other Nurses including Clinic Nurses ...	157	112·75	2	2·00	75	19·15	103	39·83	46	25·86	1	1·00	17	15·91	101·75	9·00
Social and Welfare Workers	427	385·45	45	30·05			5	3·52	17	16·50	22	15·38			35·40	320·00
Total Section 2 ...	4,155	3,859·62	260	228·67	644	118·64	235	61·10	204	156·98	246	126·62	3,163	2,831·60	3,294·94	336·01
GRAND TOTAL ...	6,376	6,052·49	401	356·41	1,747	230·57	1,729	1,029·59	1,447	903·04	765	233·78	3,173	2,832·96	5,219·94	475·61

NOTES: 1. The above table *excludes* health visiting and other staff employed by Huddersfield County Borough Council.
2. In columns (3) to (16): A = "Number employed"; B = "Whole-time staff equivalent".

APPENDIX V (*c*)

Inquiry of Local Authorities

RANGE OF DUTIES ON WHICH HEALTH VISITORS AND OTHERS ARE EMPLOYED AND WHOLE-TIME STAFF EQUIVALENT

(Staff employed at 31st December, 1953)

SCOTLAND: 1. COUNTIES

Category of Staff	Actual Number of Staff	Whole-time Staff equivalent	Administrative and Supervisory Staff		Clinic and Home Visiting Duties											Other Home Visiting Duties
					Ante-natal		Other Maternity and Child Welfare		Schools		Tuberculosis		Home Nursing and Midwifery		TOTAL of "B" columns only	TOTAL "B" only
			A	B	A	B	A	B	A	B	A	B	A	B		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
SECTION 1 *Health Visiting Staff*																
Qualified health visitors	328	326·73	37	34·50	145	12·68	256	103·78	235	61·91	188	27·24	105	65·62	271·23	16·75
"Acting" health visitors	537	534·95	3	3·00	446	28·67	485	93·18	475	50·99	369	14·41	468	310·60	497·85	18·87
Total, Section 1 ...	865	861·68	40	37·50	591	41·35	741	196·96	710	112·90	557	41·65	573	376·22	769·08	35·62
SECTION 2																
Nursing Staff and other Staff employed on home visiting duties																
Tuberculosis visitors ...	7	6·54									7	6·54			6·54	
School Nurses... ...	4	2·81							3	2·81					2·81	
Midwives and Home Nurses	296	294·50	4	4·00	71	11·96	5	1·00	21	1·04	30	0·75	291	267·40	282·15	8·35
Other Nurses including Clinic Nurses ...	3	3·00			2	1·10	1	0·30	2	1·60					3·00	
Social and Welfare Workers	36	13·57					1	1·00			1	1·00			2·00	11·57
Total, Section 2 ...	346	320·42	4	4·00	73	13·06	7	2·30	26	5·45	38	8·29	291	267·40	296·50	19·92
GRAND TOTALS ...	1,211	1,182·10	44	41·50	664	54·41	748	199·26	736	118·35	595	49·94	864	643·62	1,065·58	55·54

NOTES: 1. The above table *excludes* health visiting and other staff employed by Moray and Nairn, Orkney and Zetland County Councils.
2. In columns (3) to (16): A = "Number employed"; B = "Whole-time equivalent".

APPENDIX V (*d*)

Inquiry of Local Authorities

SUMMARY OF TABLE III

RANGE OF DUTIES ON WHICH HEALTH VISITORS AND OTHERS ARE EMPLOYED AND WHOLE-TIME STAFF EQUIVALENT

(Staff employed at 31st December, 1953)

SCOTLAND: 2. CITIES AND LARGE BURGHS

Category of Staff	Actual Number of Staff	Whole-time Staff equivalent	Administrative and Supervisory Staff		Clinic and Home Visiting Duties											Other Home Visiting Duties
					Ante-natal		Other Maternity and Child Welfare		Schools		Tuberculosis		Home Nursing and Midwifery		TOTAL of "B" columns only	TOTAL "B" only
	(1)	(2)	A (3)	B (4)	A (5)	B (6)	A (7)	B (8)	A (9)	B (10)	A (11)	B (12)	A (13)	B (14)	(15)	(16)
SECTION 1 *Health Visiting Staff*																
Qualified health visitors	512	511·00	27	22·94	280	68·75	327	205·28	190	111·75	162	70·82			456·60	31·46
"Acting" health visitors	85	82·00	2	1·25	31	3·09	46	24·47	46	32·96	21	3·30	21	13·00	76·82	3·92
Total, Section 1 ...	597	593·00	29	24·19	311	71·84	373	229·75	236	144·71	183	74·12	21	13·00	533·42	35·38
SECTION 2 *Nursing Staff and other Staff employed on home visiting duties*																
Tuberculosis visitors ...	3	3·00									3	2·75			2·75	0·25
School Nurses... ...	2	2·00							2	2·00					2·00	
Midwives and Home Nurses	555	536·50	32	32·00	39	15·09					69	7·00	518	482·41	504·50	
Other Nurses including Clinic Nurses ...	32	29·00	1	0·02	1	0·25	1	0·70	5	2·75	1	0·10			3·98	25·00
Social and Welfare Workers	14	13·00	3	3·00			1	1·00							1·00	9·00
Total, Section 2 ...	606	583·50	36	35·02	40	15·34	2	1·70	7	4·75	73	9·85	518	482·41	514·05	34·25
GRAND TOTAL ...	1,203	1,176·50	65	59·21	351	87·18	375	231·45	243	149·46	256	83·97	539	495·41	1,047·47	69·63

NOTES: 1. The above table *excludes* health visiting and other staff employed by the Arbroath and Falkirk Burgh Councils.
2. In columns (3) to (16): A = "Number employed"; B = "Whole-time staff equivalent".

APPENDIX V (*e*)

Inquiry of Local Authorities

TOTAL NUMBER OF STAFF AND WHOLE-TIME STAFF EQUIVALENT (W.S.E.) OF STAFF ENGAGED IN CERTAIN DUTIES

(Extract from Appendix V (*a*) and (*b*))

ENGLAND AND WALES

Category of Staff	1. COUNTIES						2. COUNTY BOROUGHS					
	Number of Staff		Administrative and Supervisory Duties	General Duties, Clinic and Home Visiting	Other Home Visiting Duties	Home Nursing and Midwifery	Number of Staff		Administrative and Supervisory Duties	General Duties, Clinic and Home Visiting	Other Home Visiting Duties	Home Nursing and Midwifery
	Actual	W.S.E.	W.S.E.	W.S.E.	W.S.E.	W.S.E.	Actual	W.S.E.	W.S.E.	W.S.E.	W.S.E.	W.S.E.
Qualified Health Visitors ...	4,138	4,083	200	3,346	252	286	1,724	1,701	119	1,453	128	1
Acting Health Visitors	1,319	1,272	3	717	31	520	497	492	8	472	12	negligible
TOTAL	5,457	5,355	203	4,063	283	806	2,221	2,193	127	1,925	140	1
Tuberculosis Visitors, School Nurses and other Nurses ...	473	413	1	409	3	negligible	388	336	3	308	9	16
Midwives and Home Nurses ...	7,468	7,166	173	309	39	6,644	3,340	3,138	196	119	7	2,816
Miscellaneous Social Workers ...	726	635	24	51	561	—	427	385	29	36	320	—
TOTAL	8,667	8,214	198	769	603	6,644	4,155	3,859	228	463	336	2,832

" W.S.E.":—Whole-time staff equivalent to nearest whole number.

" General Duties ":—includes ante-natal, other maternity and child welfare, schools and tuberculosis.

APPENDIX V (*f*)

Inquiry of Local Authorities

TOTAL NUMBER OF STAFF AND WHOLE-TIME STAFF EQUIVALENT (W.S.E.) OF STAFF ENGAGED IN CERTAIN DUTIES

(Extract from Appendix V (*c*) and (*d*))

SCOTLAND

Category of Staff	1. COUNTIES						2. CITIES AND LARGE BURGHS					
	Number of Staff		Administrative and Supervisory Duties	General Duties, Clinic and Home Visiting	Other Home Visiting Duties	Home Nursing and Midwifery	Number of Staff		Administrative and Supervisory Duties	General Duties, Clinic and Home Visiting	Other Home Visiting Duties	Home Nursing and Midwifery
	Actual	W.S.E.	W.S.E.	W.S.E.	W.S.E.	W.S.E.	Actual	W.S.E.	W.S.E.	W.S.E.	W.S.E.	W.S.E.
Qualified Health Visitors ...	328	327	35	206	17	66	512	511	23	457	31	—
Acting Health Visiting	537	535	3	187	19	311	85	82	1	64	4	13
TOTAL	865	862	38	393	36	377	597	593	24	521	35	13
Tuberculosis Visitors, School Nurses and other Nurses ...	14	13	—	13	—	—	37	34	negligible	9	25	negligible
Midwives and Home Nurses ...	296	294	4	15	8	267	555	537	32	22	—	483
Miscellaneous Social Workers ...	36	14	—	2	12	—	14	13	3	1	9	—
TOTAL	346	321	4	30	20	267	606	584	35	32	34	483

" W.S.E.":—Whole-time staff equivalent to nearest whole number.

" General Duties ":—includes ante-natal, other maternity and child welfare, schools and tuberculosis.

APPENDIX VI (*a*)

Inquiry of Local Authorities

RANGE OF DUTIES CARRIED OUT BY QUALIFIED HEALTH VISITORS AND OTHER NURSES IN THE SERVICE OF LOCAL EDUCATION AUTHORITIES AND NUMBERS CARRYING OUT EACH DUTY

(Staff employed at 31st December, 1953)

ENGLAND AND WALES: 1. COUNTIES

Category of Staff	Total Number Employed	Clinics		Nursery Schools and Classes	Special Schools	Routine Medical Examinations	Cleanliness Inspections	Other Nurses Surveys	Health Education in Schools	Other Duties	Home Visits	School Nurse employed whole-time at:		
		Minor Ailments	Other									Special Schools	Clinics	Other
1. *Whole-time School Nurses*														
(*a*) qualified health visitors	49	13	13	13	4	34	32	20	18	7	11	2	8	1
(*b*) not qualified health visitors	435	242	189	114	35	312	317	237	44	93	156	21	41	10
TOTAL	484	255	202	127	39	346	349	257	62	100	167	23	49	11
2. *Part-time School Nurses* (part-time other 1.a. service)														
(*a*) qualified health visitors	3,176	1,474	1,189	540	119	3,022	1,980	2,110	395	439	2,882			
(*b*) not qualified health visitors	811	202	119	52	15	765	697	299	7	72	753	1	20	
TOTAL	3,987	1,676	1,308	592	134	3,787	2,677	2,409	402	511	3,635	1	20	
3. *Part-time School Nurses* (part-time only in 1.a. service)	155	88	53	2	2	92	90	64	2	5	64	3	9	
GRAND TOTAL	4,626	2,019	1,563	721	175	4,225	3,116	2,730	466	616	3,866	27	78	11

NOTES: 1. The above table *excludes* school nursing staff employed by West Sussex County Council.

2. The item other whole-time duties carried out by school nurses includes audiometry and school camps.

APPENDIX VI (*b*)

Inquiry of Local Authorities

RANGE OF DUTIES CARRIED OUT BY QUALIFIED HEALTH VISITORS AND OTHER NURSES IN THE SERVICE OF THE LOCAL EDUCATION AUTHORITY AND NUMBERS CARRYING OUT EACH DUTY

(Staff employed at 31st December, 1953)

ENGLAND AND WALES: 2. COUNTY BOROUGHS

Category of Staff	Total Number Employed	Clinics		Nursery Schools and Classes	Special Schools	Routine Medical Examinations	Cleanliness Inspections	Other Nurses Surveys	Health Education in Schools	Other Duties	Home Visits	School Nurse employed whole-time at:		
		Minor Ailments	Other									Special Schools	Clinics	Other
1. *Whole-time School Nurses*														
(*a*) qualified health visitors	137	85	67	107	29	124	113	115	31	40	131	1	4	
(*b*) not qualified health visitors	493	313	256	232	156	371	367	323	49	159	365	28	52	3
TOTAL	630	398	323	339	185	495	480	438	80	199	496	29	56	3
2. *Part-time School Nurses* (part-time other l.a. service)														
(*a*) qualified health visitors	663	318	266	287	87	608	549	504	62	198	621	16	5	
(*b*) not qualified health visitors	80	54	51	9	6	54	50	39		16	48	2	18	
TOTAL	743	372	317	296	93	662	599	543	62	214	669	18	23	
3. *Part-time School Nurses*														
(part-time only in l.a. service)	34	25	6	3		6	7	4	1	3	8		3	3
GRAND TOTAL	1,407	795	646	638	278	1,163	1,086	985	143	416	1,173	47	82	6

NOTE: The item other whole-time duties carried out by school nurses includes ophthalmics, audiometry, ultra-violet light therapy and hospital attendance for tonsils and adenoids patients.

APPENDIX VI (*c*)

Inquiry of Local Authorities

RANGE OF DUTIES CARRIED OUT BY QUALIFIED HEALTH VISITORS AND OTHER NURSES IN THE SERVICE OF THE LOCAL EDUCATION AUTHORITY AND NUMBERS CARRYING OUT EACH DUTY

(Staff employed at 31st December, 1953)

SCOTLAND: 1. COUNTIES

Category of Staff	Total Number Employed	Clinics		Nursery Schools and Classes	Special Schools	Routine Medical Examinations	Cleanliness Inspections	Other Nurses Surveys	Health Education in Schools	Other Duties	Home Visits	School Nurse employed whole-time at		
		Minor Ailments	Other									Special Schools	Clinics	Other
1. *Whole-time School Nurses*														
(*a*) qualified health visitors	24	23	15	1	2	18	13	5	4	3	24			
(*b*) not qualified health visitors	23	20	8	3	4	12	17	5	5	4	21		1	1
TOTAL	47	43	23	4	6	30	30	10	9	7	45		1	1
2. *Part-time School Nurses* (part-time other l.a. service)														
(*a*) qualified health visitors	217	119	99	19	20	206	209	136	48	38	212			
(*b*) not qualified health visitors	501	145	104	56	55	441	478	275	73	113	463		19	
TOTAL	718	264	203	75	75	647	687	411	121	151	675		19	
3. *Part-time School Nurses* (part-time only in l.a. service)	5	2	2		1	1	3				1			
GRAND TOTAL	770	309	228	79	82	678	720	421	130	158	721		20	1

NOTES: 1. The above table *excludes* school nursing staff employed by Moray and Nairn Joint County Council.
2. The item other whole-time duties carried out by school nurses covers audiometry.

APPENDIX VI (*d*)

Inquiry of Local Authorities

RANGE OF DUTIES CARRIED OUT BY QUALIFIED HEALTH VISITORS AND OTHER NURSES IN THE SERVICE OF THE LOCAL EDUCATION AUTHORITY AND NUMBERS CARRYING OUT EACH DUTY

(Staff employed at 31st December, 1953)

SCOTLAND: 2. CITIES AND LARGE BURGHS

Category of Staff	Total Number Employed	Clinics		Nursery Schools and Classes	Special Schools	Routine Medical Examinations	Cleanliness Inspections	Other Nurses Surveys	Health Education in Schools	Other Duties	Home Visits	School Nurse employed whole-time at		
		Minor Ailments	Other									Special Schools	Clinics	Other
1. *Whole-time School Nurses*														
(*a*) qualified health visitors	82	46	4	39	23	42	23	40	3	45	22	2	20	5
(*b*) not qualified health visitors	35	28	7	5	4	14	15	23	1	2	7		6	
TOTAL	117	74	11	44	27	56	38	63	4	47	29	2	26	5
2. *Part-time School Nurses* (part-time other l.a. service)														
(*a*) qualified health visitors	115	57	62	28	3	112	112	63	16	24	99		2	
(*b*) not qualified health visitors	43	13	14	11		21	43	9	1	1	21			
TOTAL	158	70	76	39	3	133	155	72	17	25	120		2	
3. *Part-time School Nurses* (part-time only in l.a. service)	3												3	
GRAND TOTAL	278	144	87	83	30	189	193	135	21	72	149	2	31	5

NOTES: 1. The following large burghs are not local education authorities; the latter in each case being the appropriate county council.

Airdrie	Inverness
Clydebank	Motherwell and Wishaw
Hamilton	Rutherglen

2. The above table *excludes* school nursing staff employed by Arbroath Burgh Council.
3. The item of other whole-time duties carried out by school nurses includes parent craft teaching and secondment to University.

APPENDIX VII (*a*)

Survey of Health Visiting in Six Selected Areas

AVERAGE TIME SPENT BY HEALTH VISITORS ON PARTICULAR ACTIVITIES DURING ONE WEEK'S WORK

[Time in hours to one place of decimals]

Authority/Class and Number of Health Visitors	Office	Travelling	Visiting	Clinics	Other Intervals	Total
CARDIFF						
General Duties ... ... (10)	5·4	5·2	8·7	15·6	5·2	40·1
Part-time specialists						
Paediatrics ... ... (1)	5·9	10·4	9·3	8·3	6·0	39·9
Premature babies ... (1)	7·0	6·4	14·3	8·3	5·0	41·0
Average	6·5	8·4	11·8	8·3	5·5	40·5
Whole-time specialists						
Psychiatric after-care... (1)	10·7	4·8	12·1	12·8	4·9	45·3
Diabetic and Cardiac after-care ... ... (1)	2·6	4·8	8·1	20·9	5·2	41·6
Tuberculosis ... ... (1)	13·3	5·4	6·9	8·8	6·5	40·9
Mental defectives ... (1)	12·3	4·0	9·4	2·3	15·8	43·8
Average	9·7	4·8	9·1	11·2	8·1	42·9
All Health Visitors ... (16)	6·6	5·5	9·2	13·6	5·9	40·8
GLASGOW						
M. and C.W. ... ... (15)	5·2	6·1	9·2	13·0	6·1	39·6
Tuberculosis ... ... (5)	7·9	7·5	10·9	9·3	5·1	40·7
Schools ... ... (4)	0·9	2·2	0·7	30·8	5·4	40·0
Housing ... ... (4)	6·7	7·0	8·0	13·0	5·5	40·2
All Health Visitors ... (28)	5·3	5·9	8·1	14·9	5·7	39·9
NEWCASTLE						
General Duties ... ... (8)	8·2	7·5	12·0	7·2	6·0	40·9
V.D. Specialists... ... (2)	9·7	9·4	12·7	7·4	6·2	45·4
Schools ... ... (2)	2·8	3·0	3·9	22·2	7·8	39·7
All Health Visitors ... (12)	7·6	7·0	10·8	9·7	6·4	41·5
ALL COUNTY BOROUGHS						
General Duties, M. and C.W. ... ... (33)	6·0	6·2	9·7	12·4	5·8	40·1
Tuberculosis ... ... (6)	8·8	7·1	10·3	9·2	5·3	40·7
Schools ... ... (6)	1·6	2·4	1·8	27·9	6·2	39·9
Other Specialists ... (11)	7·7	7·0	10·0	10·9	6·5	42·1
All Health Visitors ... (56)	6·2	6·0	9·0	13·4	5·9	40·5
AYRSHIRE						
Qualified Health Visitors (9)	0·5	8·0	(*a*) 8·8 (*b*)12·1	4·8	4·9	39·1
Acting Health Visitors... (10)	0·5	8·2	(*a*) 9·4 (*b*)14·6	2·8	5·2	40·7
All Health Visitors ... (19)	0·5	8·1	(*a*) 9·1 (*b*)13·4	3·8	5·1	40·0
GLAMORGAN						
General Duties ... ... (14)	1·5	6·9	10·7	15·5	4·9	39·5
NORTHUMBERLAND						
General Duties ... ... (11)	7·4	4·3	10·3	12·5	5·7	40·2
ALL COUNTIES ... (44)	2·5	6·8	15·7	9·7	5·2	39·9
ALL COUNTY BOROUGHS (56)	6·2	6·0	9·0	13·4	5·9	40·5
ALL AUTHORITIES ... (100)	4·6	6·3	12·0	11·8	5·6	40·3

(*a*) Visits partly or wholly for health visiting purposes.
(*b*) Midwifery and home nursing visits.

Appendix VII (*b*)

Survey of Health Visiting in Six Selected Areas

Notes for Health Visitors Keeping Diaries

(1) Please enter your name, Authority and date on each sheet.

(2) You may use as many sheets as you like. Start a fresh sheet each day.

(3) *Time* [*Column* (*1*)]. Enter time of arrival and departure at office, clinic or visit as nearly as you can. Show also the duration of any intervals (meals, etc.). The interval between times of departure and arrival will be taken to be travelling time. Include any official activities out of working hours. Draw a line across the sheet after each item (visit, clinic, etc.).

(4) *Clinics, Office, etc.* These should be shown in proper sequence with the visits. The purpose of a clinic should be entered in column (2). The rest of the sheet (ignoring columns) should be used to describe *very briefly* what you did and who was present.

(5) *Visits.* These include any contact with " clients " whether in their homes or elsewhere but *not* at clinics. *The content of visits is the vital part of the survey.*

(6) *Object of Visit* [*Column* (*2*)]. This is to show why you made the visit. Column 2 (*a*) shows the type of *case*. Column 2 (*b*) shows the type of visit. These are coded on the back cover. Please use this to help in classifying your visits.

(7) *Brief Note on Case* [*Column* (*3*)]. What was the situation you found when you visited? What sort of family is it and what are its difficulties? When did you first visit this family and on what occasion? (Enter the family name for reference purposes.)

(8) *Problems Posed* [*Column* (*4*)]. What problems were raised by the client (apart from any matter raised by you)?

(9) *Additional Problems* [*Column* (*5*)]. What else came to your notice (apart from what is in Columns (2), (3) and (4))? What other medical, nursing, social or other worker was in touch with this family?

(10) *Action taken* [*Column* (*6*)]. What did you do or say at the time? (Put the appropriate column number against each item, if you can.) What did you note down for future action—further visit, reference to other workers, report to hospital or public health department, consultation?
(" Family " is to be taken in a wide sense, e.g. include persons living alone.)

APPENDIX VII (*c*)

Survey of Health Visiting in Six Selected Areas

Diary Sheet

(*See* Notes for Health Visitors Keeping Diaries) Name .....

Date..... (Please rule off each item) Authority .....

Time (1)	Object of Visit (2)		Brief Note on Case (3)	Problems Posed (4)	Additional Problems (5)	Action Taken (6)
	(*a*)	(*b*)				

APPENDIX VIII (*a*)

Survey of Training Centres

AGE AND CIVIL STATUS OF STUDENT HEALTH VISITORS AT COMMENCEMENT OF TRAINING

(Courses commencing during the academic year)

Course commencing during the academic year	Under 22		22 and under 23		23 and under 24		24 and under 25		25 and under 30		30 and under 35		35 and under 40		40 and under 45		45 and over		TOTAL	
	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T	S M W	T
1949–50 ...			9 1	10	27 1	28	53 2	55	278 15 2	295	198 12 9	219	102 14 1	117	38 4 3	45	4 1	5	709 50 15	774
1950–51 ...	1	1	8	8	25	25	58 1	59	252 18	270	144 18 3	165	95 13 1	109	32 5	37	2 2	4	617 57 4	678
1951–52 ...			7	7	21	21	54 1	55	217 17 2	236	149 13 4	166	79 11 4	94	30 7 4	41	7 4 1	12	564 53 15	632
1952–53 ...			12 1	13	26	26	45 2	47	194 14 3	211	173 15 8	196	78 9 4	91	33 4 2	39	4	4	565 45 17	627
1953–54 ...			12 1	13	41 1	42	29 9	38	183 19 2	204	147 22 2	171	74 15 3	92	38 14 4	56	6 1	7	530 82 11	623
TOTAL ...	1	1	48 3	51	140 2	142	239 15	254	1,124 83 9	1,216	811 80 26	917	428 62 13	503	171 34 13	218	23 8 1	32	2,985 287 62	3,334

NOTES: 1. All training authorities in England, Wales and Scotland are included in the above Table.
2. The training course organised by Middlesex C.C. commenced in the academic year 1950–51.
3. The training course organised by the County Board for training Health Visitors at Durham was not held during the year 1950–51.
4. The training course organised by Queen Elizabeth College, London was transferred to the Institute of Education, London with effect from September, 1953.

APPENDIX VIII (*b*)

Survey of Training Centres

SELECTION OF STUDENT HEALTH VISITORS

(Courses commencing during the academic year)

Course commencing during the academic year	Number of training courses	Average length of courses (in months)	Number of places available at training centres	Training Centres		Local Authorities	Total	Number not completing training	Number sitting for examination	Number failing at first attempt	Number of students accepted with qualifications	
				Number of applicants to centres	Number accepted for training	Number sent to centres					School Cert. or equivalent	Part II Midwifery
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1949–50 ...	32	7·0	819	644	517	260	777	13	764	107	223	452
1950–51 ...	29	7·8	802	577	423	251	674	9	665	83	231	458
1951–52 ...	30	8·1	821	639	353	277	630	12	618	83	215	504
1952–53 ...	28	8·6	740	627	378	244	622	13	609	92	232	473
1953–54 ...	28	8·6	734	615	381	241	622	17	605	70	233	458

NOTES: 1. All training authorities in England, Wales and Scotland are included in the above Table.
2. The training course organised by Middlesex C.C. commenced in the academic year 1950–51.
3. The training course organised by the County Board for training Health Visitors at Durham was not held during the year 1950–51.
4. The training course organised by Queen Elizabeth College, London was transferred to the Institute of Education, London with effect from September, 1953.
5. Battersea Polytechnic organises 3 training courses a year. Two training courses a year were organised by Leicester C.B. in 1949–50 and 1951–52, Q.I.D.N. at Brighton in 1949–50 and 1950–51, and at Bolton in 1949–50, 1950–51 and 1951–52, and by Southampton Joint Board in 1949–50.
6. Information under column (4) was not provided by Battersea Polytechnic for 1949–50 and 1950–51, and by Oxfordshire C.C. for 1949–50, 1950–51 and 1951–52.
Information under column (11) was not provided by Battersea Polytechnic for 1949–50, by Oxfordshire C.C. for 1949–50 and 1950–51, by Aberdeen Corporation for 1949–50, 1950–51 and 1951–52, and that provided by Edinburgh Corporation for all years except 1953–54 was incomplete.
Information under column (12) was not provided by Battersea Polytechnic for 1949–50, by Oxfordshire C.C. for 1949–50 and 1950–51, and by Leeds University for 1950–51.

List of Tables in the Text

SUBJECT INDEX

Main subjects are classified alphabetically.

Subsidiary subjects are classified in the order in which they are first mentioned in the report.

Paragraph numbers in Part III (Review and Recommendations), are in heavy type.

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